SECOND EDITION

HANDBOOK OF LGBTQ-AFFIRMATIVE COUPLE AND FAMILY THERAPY

Edited by REBECCA HARVEY, MEGAN J. MURPHY, JERRY J. BIGNER, AND JOSEPH L. WETCHLER

ROUTLEDGE

"The Handbook of LGBTQ Affirmative Couple and Family Therapy does full justice to the enormous diversity within the LGBTQ community. Each chapter is an eye-opening and rewarding reading experience. The book abounds with specific treatment guidelines and clinical case examples for practitioners. An impressive achievement!"

—Robert-Jay Green, PhD; Distinguished Professor Emeritus, California School of Professional Psychology at Alliant International University

"Social justice meets psychotherapy in this timely innovative book. These diverse authors demonstrate how to identify and transform oppressive narratives about race, gender, and sexuality interwoven not only in LGBTQ couple and family life but in training and supervision practices. The breadth of content includes often neglected topics for LGBTQ clients such as sex therapy, elders, spirituality, and divorce. It is time to queer the field of couple and family therapy for clients of all races, genders, and sexual experiences. This book leads the way."

—Suzanne Iasenza, PhD; author of Transforming Sexual Narratives: A Relational Approach to Sex Therapy *(Routledge, 2020)*

"This comprehensive text should be required reading for every family therapist, psychologist, and social worker. It is superbly written, conveying complex ideas in a clear, thoughtful, practical, and useful way. The authors offer an expansive contextual perspective on intersectionality, resilience, and support from 'outside the margins,' with excellent case examples, thoughtful and practical clinical suggestions, and a hopeful, resilience-focused orientation toward even the most complex and difficult case situations."

—Monica McGoldrick, MSW, PhD (h.c.); Director, Multicultural Family Institute; Clinical Associate Professor of Psychiatry, RWJ Medical School, Rutgers University

Taylor & Francis
Taylor & Francis Group
http://taylorandfrancis.com

Handbook of LGBTQ Affirmative Couple and Family Therapy

This comprehensive second edition inspires therapists to utilize clinical work to pragmatically address intersectional oppressions, lessen the burden of minority stress, and implement effective LGBTQ affirmative therapy.

A unique and important contribution to LGBTQ literature, this handbook includes both new and updated chapters reflecting cutting-edge intersectional themes like race, ethnicity, polyamory, and monosexual normativity. A host of expert contributors outline best practices in affirmative therapy, inspiring therapists to guide LGBTQ clients into deconstructing the heteronormative power imbalances that undermine LGBTQ relationships and families. There is also an increased focus on clinical application, with fresh vignettes included throughout to highlight effective treatment strategies.

Couple and family therapists and clinicians working with LGBTQ clients, and those interested in implementing affirmative therapy in their practice, will find this updated handbook essential.

Rebecca Harvey, PhD, is Professor of Marriage and Family Therapy at Southern Connecticut State University in New Haven, Connecticut. She has been proudly queering family therapy practice, supervision, and training for over 25 years. Dr. Harvey is co-author of the book *Nurturing Queer Youth: Family Therapy Transformed*.

Megan J. Murphy, PhD, is Professor and Director of the Couple and Family Therapy Program at Purdue University Northwest in Hammond, Indiana. She is co-editor with Dr. Lorna Hecker of *Ethics and Professional Issues in Couple and Family Therapy* (2nd edition).

Jerry J. Bigner, PhD, was Professor Emeritus in the Department of Human Development and Family Studies at Colorado State University, and was the editor of the *Journal of GLBT Family Studies*. He has had over 50 research publications and 20 chapters in texts relating to parent-child relations as well as gay and lesbian family issues.

Joseph L. Wetchler, PhD, is Professor Emeritus of Marriage and Family Therapy at Purdue University Northwest. He formerly served as Editor of the *Journal of Couple and Relationship Therapy* and as Associate Editor of the *Journal of GLBT Family Studies*.

Taylor & Francis
Taylor & Francis Group
http://taylorandfrancis.com

Handbook of LGBTQ Affirmative Couple and Family Therapy

2nd edition

Edited by
Rebecca Harvey, Megan J. Murphy, Jerry J. Bigner and Joseph L. Wetchler

Routledge
Taylor & Francis Group
NEW YORK AND LONDON

Second edition published 2022
by Routledge
605 Third Avenue, New York, NY 10158

and by Routledge
2 Park Square, Milton Park, Abingdon, Oxon, OX14 4RN

Routledge is an imprint of the Taylor & Francis Group, an informa business

© 2022 selection and editorial matter, Rebecca Harvey, Megan J. Murphy, Jerry J. Bigner, and Joseph L. Wetchler; individual chapters, the contributors

The right of Rebecca Harvey, Megan J. Murphy, Jerry J. Bigner, and Joseph L. Wetchler to be identified as the authors of the editorial material, and of the authors for their individual chapters, has been asserted in accordance with sections 77 and 78 of the Copyright, Designs and Patents Act 1988.

All rights reserved. No part of this book may be reprinted or reproduced or utilised in any form or by any electronic, mechanical, or other means, now known or hereafter invented, including photocopying and recording, or in any information storage or retrieval system, without permission in writing from the publishers.

Trademark notice: Product or corporate names may be trademarks or registered trademarks, and are used only for identification and explanation without intent to infringe.

First edition published by Routledge 2012

Library of Congress Cataloging-in-Publication Data
A catalog record has been requested for this book

ISBN: 978-0-367-20656-7 (hbk)
ISBN: 978-0-367-22387-8 (pbk)
ISBN: 978-0-429-27462-6 (ebk)

DOI: 10.4324/9780429274626

Typeset in Minion Pro
by codeMantra

This book is dedicated to all gender and sexual minorities, transgender and gender expansive, and queer people who—by way of being—share their gifts with the world through their resilience.

Taylor & Francis
Taylor & Francis Group
http://taylorandfrancis.com

Contents

Acknowledgments xiii
List of Contributors xv

Introduction 1
REBECCA HARVEY and MEGAN J. MURPHY

Section I Foundations of LGBTQ Affirmative Therapy

1 Evolution of LGBTQ Affirmative Couple and Family Therapy 9
REBECCA HARVEY, MEGAN J. MURPHY and TRACEY A. LASZLOFFY

2 Intercultural Issues in LGBTQ+ Couple and Family Therapy: Supporting Empowerment and Resilience at the Intersection of Identities 25
AMNEY J. HARPER and ANNELIESE A. SINGH

3 Heteronormativity and Ethics in the Treatment of LGBTQ Clients 45
MEGAN J. MURPHY

Section II Working with Couples

4 We Cannot Change What We Cannot Name for Ourselves: Integrating Attachment Theory into Couple Therapy with Gay Men 61
ROBERT ALLAN

5 Illuminating Strengths: Multiracial Feminist Couple Therapy with Queer Women 75
MONTINIQUE MCEACHERN, DEBORAH COOLHART and DYANE WATSON

6 "There's a Lot We Don't Understand About Each Other": Centering Bisexual Partners in Couple Therapy 89
ERICA E. HARTWELL, KATIE M. HEIDEN-ROOTES and STEPH COOKE

7 Therapists' Accountability and Engagement with Transgender and Nonbinary Couples 105
LIVINGSTONE CARTER COX, KRISTEN E. BENSON and ALEX IANTAFFI

8 Affirming Diversity and Targeting Pleasure: Sex Therapy for Gay Male Couples 121
MARIA MANUELA PEIXOTO

9 "I Could *Never* See You and Now I *Dare Not* Touch You": Sex Therapy with Lesbian Couples 135
BROOKS A. BULL and JASSY CASELLA TIMBERLAKE

10 Sexuality and Desire Landscapes in Transgender, Nonbinary, and Genderqueer Relationships 149
ARLENE I. LEV and SHANNON L. SENNOTT

11 Therapeutic Considerations in Same-Sex Divorce and Relationship Dissolution 175
KEVIN P. LYNESS

Section III Family and Identity Considerations

12 Invisible Humans: Identity Development and Visibility Management in Gender, Sexual, Erotic, and Relational Diversity 195
MARKIE LOUISE CHRISTENSON (L. C.) TWIST, RAVEN CLOUD and SARAH A. HECHTER

13 I Have Too Many Mothers: Queer Families Raising Children 225
LINDA STONE FISH

14 Affirming Queerness: Raising Happy, Healthy Children 239
REBECCA HARVEY, PAUL D. LEVATINO, JONATHAN RUIZ, and LINDA STONE FISH

15 Gender Affirmative Therapy with Trans and Gender Expansive (TGE) Youth and Families: Listening to Youth and Thoughtfully Following Their Lead 259
DEBORAH COOLHART and TRISTAN K. MARTIN

16 Helping LGBTQ Stepfamilies Meet Their Challenges 277
PATRICIA L. PAPERNOW

17 "I Will Always Come Home to You": Affirmative Therapy with Clients Practicing Consensual Non-Monogamy 297
SHEILA M. ADDISON and NOELLE CLASON

Section IV Special Issues

18 "I Didn't Know I Had a Right to Exist": Queer Elders and Family Therapy 327
PAUL D. LEVATINO

19 Where Should We Go to Church? Or Should We Even Bother: Spirituality and Religion in LGB Couples' Therapy 347
STEVEN D. JOHNSON, SHARON S. ROSTOSKY, and ELLEN D. B. RIGGLE

20 Treatment of Partner Violence in Sexual and Gender Minority Couples 363
NATHAN MATHER, DEANNA LINVILLE, and TIFFANY B. BROWN

21 Treating LGBT Couples Experiencing Substance Use Disorders: Trauma-Informed and Affirmative Therapy Approaches 381
MICHAEL SHELTON

22 Rewrite the Script: A Call for More Queer and Inclusive Couple Enrichment Programs 401
SHOSHANA D. KEREWSKY, DARIEN T. COMBS, and NATHAN MATHER

Section V Training Issues

23 "Why Can't We Just Learn about Normal Couples?": LGBQ Affirmative Training Strategies for CFT Faculty and Programs 417
CHRISTI R. MCGEORGE, ASHLEY A. WALSDORF, and KATELYN O. COBURN

24 Self-Disclosure: Considerations for Therapy and Supervision 433
STEPH COOKE, MARY R. NEDELA, DARAN SHIPMAN, and ERIKA L. GRAFSKY

25 Recovery from Sexual Orientation Change Efforts: Affirming the Intersections of Marginalized Identities among Survivors 449
JEFFREY S. LUTES

26 Getting Personal: Queer Supervision 465
JANIE K. LONG, JACK GROTE, KYRA E. CITRON, MELANIE CAMEJO COFFIGNY, MANISH KUMAR, TYLER LIAN, and SHOM TIWARI

Index 479

Taylor & Francis
Taylor & Francis Group
http://taylorandfrancis.com

Acknowledgments

So many people to thank who have made this book possible!

First, it has been a delight and honor to work with Dr. Megan Murphy. I admire so much about her: her practical, calm, working-class energy, her rigor, her humility and incisive strength. We share an impatience for artifice but a love for the aspirational. Thank you for everything Megan!

I want to thank the chapter authors for giving Megan and I the leeway to focus this book and their work in the specific ways we did. We endeavored to create a book that would highlight their important contributions as we consider them leaders in our field and their voices vital.

I'd like to thank those at Routledge especially Clare Ashworth, Ellie Duncan, and Heather Evans who were always professional and kind, encouraging and also patient as we navigated a bulk of this work through a global pandemic.

Thanks to all those who generously mentored me especially Ellie Macklin and Linda Stone Fish who saw something in me and helped me find it in myself. Also, very grateful to Bonny Slim for walking with me in the darkest of times, helping me to trust my gifts, and generally being a badass in the kindest, understated, midwestern sort of way.

Appreciation for all my friends who love and respect me enough to be real with me. Thanks especially to Paul Levatino for his insight, dedication, witty repartee, and bawdy jokes not necessarily in that order. Thanks to Susan Eichenberger … for the walks, the respite, the trust, and the well-placed gin and tonics. Thanks to Tracey Laszloffy for her stalwart, brilliant, and generous presence Big shout out to the Mom Squad, Alexis Munson, and Shonna Marshall for knowing where the parenting went awry and where the bodies are buried but showing up for PLB anyway, my deepest gratitude.

Thanks to my dad, Paul, for being affirming to me before I understood what that was. And for introducing me to Provincetown as a teenager. That *truly* changed my life.

Thanks to my mom, Barb, for modeling courage and teaching me how to show up and do the right thing even if it was hard. She instinctively taught me to trust marginalized people with a compassion and commitment which I have worked hard to emulate. She may have been the first in her line of brave feminists but definitely not the last!

Thanks to my sister, Heather, for a lifetime of true friendship with all of its ups and downs, tears and laughs, and for generously sharing her many remarkable gifts, including the artwork for this bookcover. Still no one I'd rather hang with than, funny, original, fierce, north side, you.

Thanks to Kris for her uncanny ability to be herself: sweet, smart, brave, unique, and fun. Which has made it easier for me to do the same. So grateful for the joy and wonder of having met you. We were worth the wait.

A big huge thank you you to my daughter, Sophia (next in the line of loving, bad ass feminists), who made and ate a lot of ramen noodles during the completion of this book. I am so grateful to Sophia for her commitment to our queer family and for her thoughtful challenges as well as the generosity of our late night conversations about life when we (she) ought to have been asleep. Watching her grow into her strength and her kindness is a marvel and a privilege.

Rebecca Harvey

Sincerest thank you to the authors of the chapters in this book for their contributions as they captured the changes that have taken place since the publication of the first edition, and for their patience as we worked on this book through the COVID pandemic. Appreciation goes to Heather Evans, Ellie Duncan, and Clare Ashworth for their guidance in putting this book together. Thank you to Joe Wetchler for entrusting me to edit the 2nd edition of the *Handbook*. I am thankful to have had the opportunity to know Jerry Bigner as an instructor and later colleague—I hope we were able to bring forward his energy and enthusiasm to this 2nd edition. I appreciate Gardenia Alvarez's assistance in keeping me organized and providing the behind-the-scenes help as a graduate assistant.

I am very thankful to have Dr. Rebecca Harvey as co-editor and friend, with her absolute brilliance, creativity, and ability to keep me grounded. I could not have done this without you!

And I am so grateful to my husband, Joe, for his support, encouragement, and feedback on this project. Thank you for being there with me.

Megan J. Murphy

Contributors

Sheila M. Addison, PhD
Couple & Family Therapy Program
Antioch University Seattle
Seattle, Washington

Robert Allan, PhD
Couple and Family Therapy Program
University of Colorado Denver
Denver, Colorado

Kristen E. Benson, PhD
Appalachian State University
Boone, North Carolina

Tiffany B. Brown, PhD
Department of Family and Human Services
University of Oregon
Eugene, Oregon

Brooks A. Bull, PhD
Collaborative Therapy & Coaching, PLLC
Northampton, Massachusetts

Kyra E. Citron, BA
Stanford University, School of Medicine
Palo Alto, California

Noelle Clason, MA
California Institute of Integral Studies
Albany, California

Raven Cloud, MS
Las Vegas, Nevada

Katelyn O. Coburn, MS
Couple and Family Therapy Program
Kansas State University
Manhattan, Kansas

Melanie Camejo Coffigny, BA
Duke University
Durham, North Carolina

Darien T. Combs, MS, MEd
Counseling Psychology Program
University of Oregon
Eugene, Oregon

Steph Cooke, MA
Human Development and Family Science
Virginia Tech
Blacksburg, Virginia

Deborah Coolhart, PhD
Marriage and Family Therapy Program
Syracuse University
Syracuse, New York

Livingstone Carter Cox, MS
Harvard College
Office of BGLTQ Student Life
Cambridge, Massachusetts

Erika L. Grafsky, PhD
Human Development and Family Science
Virginia Tech
Blacksburg, Virginia

Jack Grote, JD
Atlanta Legal Aid Services
Atlanta, Georgia

Amney J. Harper, PhD
University of Wisconsin Oshkosh
Oshkosh, Wisconsin

Erica E. Hartwell, PhD
Marriage & Family Therapy Program
Fairfield University
Fairfield, Connecticut

Sarah A. Hechter, MS
Plainfield, Illinois

Katie M. Heiden-Rootes, PhD
Medical Family Therapy Program
Department of Family & Community Medicine
Saint Louis University
St. Louis, Missouri

Alex Iantaffi, PhD
Edges Wellness Center
Minneapolis, Minnesota

Steven D. Johnson, PhD
Department of Psychiatry
University of Kentucky
Lexington, Kentucky

Shoshana D. Kerewsky, PsyD
Counseling Psychology and Human Services Department
University of Oregon
Eugene, Oregon

Manish Kumar, BA
Duke University
Durham, North Carolina

Tracey A. Laszloffy, PhD
Center for Healing Connections
Norwich, Connecticut

Arlene I. Lev, MSW, LCSW-R, CASAC, CST
Choices Counseling and Consulting &
University at Albany, School of Social Welfare
Albany, New York

Paul D. Levatino, LMFT
Marriage and Family Therapy Program
Southern Connecticut State University
New Haven, Connecticut

Tyler Lian, BS
Duke University
Durham, North Carolina

Deanna Linville, PhD
Department of Family and Human Services
University of Oregon
Eugene, Oregon

Janie K. Long, PhD
Duke University
Durham, North Carolina

Jeffrey S. Lutes, MS
Private Practice
Austin, Texas

Kevin P. Lyness, PhD
Antioch University New England
Keene, New Hampshire

Tristan K. Martin, PhD
Syracuse University & Synergy Center
Manlius, New York

Nathan Mather, MS
Department of Family and Human Services
University of Oregon
Eugene, Oregon

Montinique McEachern, PhD
Marriage and Family Therapy Program
Syracuse University
Syracuse, New York

Christi R. McGeorge, PhD
Human Development and Family Science
North Dakota State University
Fargo, North Dakota

Mary R. Nedela, PhD
Department of Counselor Education and Family Therapy
Central Connecticut State University
New Britain, Connecticut

Patricia L. Papernow, PhD
Institute for Stepfamily Education
Hudson, Massachusetts

Maria Manuela Peixoto, PhD
Psychology for Positive Development Research Center
Lusíada University of Porto
Porto, Portugal

Ellen D. B. Riggle, PhD
Department of Gender and Women's Studies and
Department of Political Science
University of Kentucky
Lexington, Kentucky

Sharon S. Rostosky, PhD
Educational, School, and Counseling Psychology
University of Kentucky
Lexington, Kentucky

Jonathan Ruiz, LMFT
Hamden, Connecticut

Shannon L. Sennott, MSW
Center for Psychotherapy and Social Justice, Translate Gender, Inc.
Smith School for Social Work
Northampton, Massachusetts

Michael Shelton, MS, LPC, CAADC
Community and Trauma Counseling Program
Thomas Jefferson University
Philadelphia, Pennsylvania

Daran Shipman, MA
Marriage & Family Therapy
Syracuse University
Syracuse, New York

Anneliese A. Singh, PhD, LPC
Tulane University
New Orleans, Louisiana

Linda Stone Fish, PhD
Department of Marriage and Family Therapy
Syracuse University
Syracuse, New York

Jassy Casella Timberlake, MEd
Northampton Sex Therapy, LLC
Florence, Massachusetts

Shom Tiwari, BA
Lead for North Carolina Fellowship
University of North Carolina School of Government
Elizabeth City, North Carolina

Markie Louise Christianson (L. C.) Twist, PhD
Department of Human Development and Family Studies
Marriage and Family Therapy Program
University of Wisconsin-Stout
Menomonie, Wisconsin

Ashley A. Walsdorf, PhD
Human Development and Family Science
University of Georgia
Athens, Georgia

Dyane Watson, PhD
Marriage and Family Therapy Program
Syracuse University
Syracuse, New York

Taylor & Francis
Taylor & Francis Group
http://taylorandfrancis.com

Introduction

REBECCA HARVEY and MEGAN J. MURPHY

As editors, we want to begin by acknowledging how truly groundbreaking the first edition of the *Handbook* was when it came out in 2012. With affirmative therapy still in its infancy the editors and contributing authors were truly leading the field and their work raised important and difficult questions. For example, including affirming couples interventions, and premarital or marriage preparation programs for LGBTQIA people in a time when same-sex marriage was not legal (at the federal level in the U.S.) and was highly politicized led to queries about the field's assumptions about the nature of marriages, the legitimacy of LGBTQIA couples and families, and the impact of widespread stigma on their relationships. In a similar vein, it took integrity and courage to include a chapter on domestic violence knowing that to acknowledge violence which occurs in some LGBTQIA relationships could provide fuel to anti-LGBTQIA efforts. In short, the *Handbook* was a proclamation of the relevance, importance, and complexity of LGBTQIA people and relationships. And many of us marriage and family therapists, supervisors, faculty, and students owned and referred often to this volume over the years.

When we began this project, we knew that a 2nd edition of the *Handbook* was necessary—even imperative—given the rapid changes experienced in the field and in U.S. culture as a whole. Affirmative therapy is evolving in a time when the dichotomies of the past—dichotomies upon which much of society has been founded and organized—are being called to question.

The gender binary, while certainly entrenched, is becoming (especially among young people) a gender spectrum where many different ways of being are possible. This turns a discussion of sexual orientation on its head, complicating notions of being "oriented" to one or both of two possible genders into considerations of ways to be oriented to many (or few or even no) genders.

No longer constrained by thinking of gender as an either/or prospect allows for a more expansive understandings of what a gender transition might entail and substantially broadens participation. For who among us is not transitioning in some way, shape, or form in our own identity project?

The intersectional nature of oppression has been firmly established by Black and Brown intellectuals and scholars. As James Baldwin (1985) gracefully and provocatively points out, the idealized cultural stories we tell about race, sexuality, and gender are inevitably and completely bound together, laced through with violence and oppression. Baldwin (1985) writes of the U.S.:

> All countries or groups make of their trials a legend or, as in the case of Europe, a dubious romance called "history." But no other country has ever made so successful and glamorous a romance out of genocide and slavery; therefore, perhaps the word I am searching for is not idea but ideal.
>
> The American ideal, then, of sexuality appears to be rooted in the American ideal of masculinity. This ideal has created cowboys and Indians, good guys and bad guys, punks and studs, tough guys and softies, butch and faggot, black and white. It is an ideal so paralytically infantile that it is virtually forbidden—as an unpatriotic act—that the American boy evolve into the complexity of manhood.

DOI: 10.4324/9780429274626-1

These idealized stories (and the oppression they legitimize) become normalized, widely integrated myths which validate and empower some lives just as other types of lives lived are disqualified. In this way, the range of possibilities for each of us is decided and clarified. Based on the intersections of where we come from, what we look like, how we embody gender, or who and how we love or desire, we each learn our place and receive instructions for how to consider and treat one another. To challenge these myths by recognizing and trying to evolve out of their very serious limitations (as LGBTQIA, Black, Brown, working-class, immigrant people among others have repeatedly endeavored to do) is to be anathema and often to be detested to the point of dehumanization. The fingerprints of this are all over the culture, within family and relational processes large and small, certainly within the mental health fields, including marriage and family therapy and by extension solidly entrenched even within affirmative therapy. To redress the harm done by any one of these stories is to be confronted with all of these narratives at once and the complicated way they are layered on top of one another in our own lives and the lives of our clients. To remedy heteronormative oppression, one must also address patriarchy, and to accomplish that one must also acknowledge and rectify white supremacy, along with classism and colonialism. And this is a part of the reason that a 2nd edition of the *Handbook* was necessary—to broaden the focus of affirmative therapy to address heteronormativity and intersectionality and to explore how clinical work can address societal level injustice with specificity and rigor in order to become truly affirming to all LGBTQIA people.

We came to this project in a tumultuous sociopolitical time when long-simmering divisions have been stoked and manipulated, erupting in a breakdown of civility and brazen acts of racist, misogynistic insurrection, aggression, and violence. As human beings, our tribal identities across lines of race, gender, and sexuality (among others) have always been used to pit us against one another, our own insecurities and resentments exploited as political strategies—all of which leads us to the somber place we find ourselves today as these same strategies are being employed in extraordinarily debased ways to nakedly serve the most powerful and the most privileged at the expense of the most vulnerable. Times like these always fall hard on LGBTQIA people and especially transgender Black and Brown folx who are a favored political punching bag. The ambitious and the powerful, as always, freely trade on anti-LGBTQIA sentiment to solidify political capital.

As systemic thinkers in the middle of this current context, we find the question of whether to address societal injustice within therapy—and the lack of progress in doing so—frustrating. The question has been asked and answered. Oppression at the societal level sparks parallel processes within therapy sessions and within intimate relationships. Power influences systemic processes at all levels. And that power can be used to dominate and undermine, or to collaborate and nurture. It is not a question of whether we have power, both collectively as a field and individually as practitioners, only how we decide to utilize whatever imperfect power we have.

Language and Labels

Frankly, one important and ongoing dilemma for affirmative therapy that is evident in this book involves terminology. The language one uses or is labeled with by others raises questions of inclusion and exclusion as well as agency, privilege, and power. The reader will note that beginning with the title of this 2nd edition, we intentionally include "Q" as we wanted to specifically include people who identify as queer in the title and content of the book. We use queer (as many LGBTQIA people have come to do) as a proud reconditioning of a word used historically to isolate, demean, and diminish LGBTQIA people. We also prefer it because it resists heteronormative classifications, and highlights the gifts, resilience, and contributions offered by lives lived outside of heteronormativity.

Next, the reader will note that the authors who contributed to this book are not of one mind when it comes to language. Though we have aimed for consistent use of terminology whenever possible, it became readily apparent to us as we edited that there are various levels of inclusion when it comes to LGBTQIA terminology. This is the state of the field. As editors, we ourselves have learned from and been stretched by the work of the chapter authors in this *Handbook*. This is part of the reality of affirmative therapy. We are challenged to develop and use common terminology and shared meaning without being overly constrained by ideas tainted by heternormativity, which are just simply not useful or out of date. In other cases, while recognizing that relationship forms and structures are quite varied, some authors decided to focus on couples to the exclusion of other relationship forms.

We also made an intentional decision to capitalize references to oppressed racial groups, such as Black, Asian, and Latinx, while not capitalizing "white" in an effort to elevate and privilege marginalized voices. We recognize that this goes against the current 7th edition of the American Psychological Association Manual, but we believe that it is the right thing to do. We have embraced the use of "they/them" pronouns, even when preceded in sentences by singular pronouns. We have eschewed the imposition of he/she, him/her, or other common uses of binaries (unless clients explicitly identified themselves along these binaries) that, we believe, further us-them "othering" that is not helpful or healthy, or representative of the complexity of the human condition.

We recognize and acknowledge that the use of language is a multi-faceted, contested, significant, and defining issue which we will not solve with the publication of this *Handbook*. Where to draw the line is an ongoing question that we all will struggle with in our personal and professional relationships. What we might be certain of—if anything—is that meanings are going to shift and change over time, and that we all play a part in contributing to challenging discourses in our conversations with others.

Marriage Equality

Since the first edition was published, same-sex marriage was legalized at the federal level by the *Obergefell* decision issued by the U.S. Supreme Court in 2015. This somewhat unexpected ruling signified a major shift in recognition of the legitimacy of same-sex relationships. It was cheered by many in the LGBTQIA community as it provided visibility and validation to same-sex couples along with cultural privileges that come with marriage. Many got married as soon as they were able, to share in the cultural meaning of marriage and to symbolize the depth of their commitments to their partners with their friends and communities. This was also moving and affirming to many LGBTQIA people, married or not, who felt a sense of full belonging and access to full legal recognition for the first time in their lives.

Still others worried that same-sex marriage came at the price of increasing the burden of minority stress and upholding the oppressive model of traditional, heteronormative marriage as the standard for healthy relationships and family structure. LGBTQIA relationships often queer traditional notions of marriage and call into question all its most sacred assumptions: that only two people can be in a healthy relationship at a time, that success is defined mainly by not divorcing, that relational commitments generally end with divorce, or that parenting ought only to occur within the frame of marriage and a nuclear family.

Indeed, LGBTQIA relationships routinely challenge gender role expectations, as they are often marked by open discussions about expectations regarding sexuality and monogamy, and higher levels of relational equality. LGBTQIA relationships have demonstrated a capacity to maintain lifelong commitments and a sense of ongoing dedication to ex-partner(s) which extends after—sometimes long after—the dissolution of a marital relationship. These challenges to the bedrock of heteronormative marriage—the very ideas used to stigmatize or minimize

LGBTQIA relationships—are also skills, ideas, and practices which create more intimate, flexible, vibrant marriages. They are also open challenges to the status quo notion that healthy *marriage*, *sexuality*, and *families* belong solely to traditional, monogamous nuclear family systems. Therapists must be aware of the emotional and relational toll it can take on LGBTQIA clients to have their lives and relationships seen by others as rebellious, disrespectful, or even threatening acts. No matter what legalization of marriage accomplishes, it does not necessarily change the hearts and minds of family and friends who continue to view same-sex relationships as deviant, pathological, or immoral. And any progress made in policy or attitude does not minimize the depth of the oppression or hostility that some of us avoid and others must endure based on our unique transgressions of the status quo. And thus Crenshaw's (and others) intersectional critique becomes such an important concept for affirmative therapy to address.

Affirmative therapists need to continue to challenge this deficit model of LGBTQIA experience and, despite increasing polarization, take a definitive stand protecting LGBTQIA families, honoring how diverse notions of marriage and family structure strengthen rather than threaten all marital and family relations. LGBTQIA people have developed relational ideas, processes, and norms which evolved out of living and navigating on the margins. This has led to a sense of freedom to create and recreate relational structures that are egalitarian, flexible, and creative models of commitment. These new structures are now more readily available to all participants in marriage, no matter their orientation or gender identity, who have been unsatisfied with the power imbalances and rigidity of traditional marriage.

Heteronormativity

LGBTQIA people of all races and from all backgrounds must still reckon with the pervasive constraining influence of heteronormativity—the idea that heterosexuality is the preferred or "normal" sexual orientation—that is ever-present at all levels in governmental and workplace policies, within mental health diagnoses and medical paperwork, and within relationships and relational expectations.

Certainly, LGBTQIA people are resilient and most find ways to cope with pervasive heteronormativity; however, the effects of minority stress can be devastating to LGBTQIA people via increased rates of poverty, family cut-off, self-harm, suicide, drinking and other drug use, and interpersonal difficulties. And while much social progress has been made in the last decade, there has been a demonstrable backlash against this very progress that has most specifically fallen on transgender and nonbinary people especially those who are Black and Brown.

While acceptance and support for LGBTQIA people and families are globally at an all-time high, we are also experiencing a global wave of reactionary right-wing authoritarianism where governments intentionally fuel fear and hatred, and condone violence against LGBTQIA people, people of color, immigrants, women, and religious minorities for political gain. We are on a roller coaster ride of combative and reactionary policy decisions regarding LGBTQIA people. One President of the U.S. (Obama) ended the U.S. military policy banning transgender soldiers from serving in the military, only to have the next U.S. President (Trump) re-institute this ban. The U.S. Supreme Court rendered a decision supporting religious freedom arguments allowing discrimination against LGBTQIA people and families when such discrimination is based on religious conviction. And yet the same Supreme Court decides to protect LGBTQIA people from employment discrimination. Even the most recent U.S. Census has become part of this trend as officials have decided to reverse course and remove questions included for the first time in the previous census aimed at identifying LGBTQIA-headed households, effectively erasing these households in the official roles of the government. As these trends occur, a spike in LGBTQIA hate crimes has occurred across the country, with transfeminine women of color being at highest risk.

Intersectionality

Intersectionality—the interconnected identities that impact privilege and oppression experienced in society—first appeared in the late 1980s with Kimberlé Crenshaw's work, and was included in the family studies literature in the 1990s and 2000s, with a real explosion in focus in the 2010s. The idea of intersectionality poses critical questions for addressing the mental health concerns of clients who identify as LGBTQIA. Yet, the field of family therapy has lagged behind in incorporating intersectionality into theoretical tenets and practical interventions—and intersectionality is still not widely acknowledged in the field or taught in family therapy programs.

We are finalizing this edition against the backdrop of a heightened Black Lives Matter movement with associated civil unrest and protesting against the senseless killing of so many Black people, including Breonna Taylor, George Floyd, Atatiana Jefferson, Rayshard Brooks, and Daniel Prude. We grapple with the continued centering of whiteness within LGBTQIA studies and in LGBTQIA-affirmative family therapy. We must ask: who are we affirming when we conduct affirmative therapy? When we write or read about "lesbian couples," are we implicitly imagining white lesbian couples? There is evidence to suggest that for many white therapists, this is the case. In a parallel way, we hope to trouble the rigid categories of sexuality and gender. Transgender, nonbinary, and bisexual folx inherently challenge the status quo through their very being which has prevented them from being given full consideration. Using the previous example, when considering "lesbian couples," it would be easy, perhaps common, to erase the potential bisexual identity or the potential transgender identity of these partners if we cleave to these rigid categories. Intersectionality calls for an explicit naming of identities, including those of our clients and of ourselves. It calls us to account for intersectionality in our scholarly work, research, case studies, and classrooms. Indeed, it also callus upon us to name and understand our own intersectional experiences. We (RH & MJM) come to this work as two white people and as such we have benefitted from unearned privileges that white people commonly assume. We have blind spots and are doing anti-racist work imperfectly. Having two white editors is certainly a limitation of the current edition and we hope that, moving forward, more marginalized people will be empowered to speak and write about their own experiences. As a field and as individuals, we need to encourage and support these efforts wherever possible. We know as editors that we have fallen short of our own aspirational hope in publishing this book. We have taken some small steps to ameliorate these shortcomings, knowing that it is not enough.

Our aim is to present a comprehensive *Handbook* that pushes the boundaries of the field and that challenges chapter authors to step into intersectionality, to highlight the importance of seeing relationships in all their wonderful complexity while attending and attuning to experiences of privilege and oppression that play out in relationships. We wanted an explicit focus on experiences of oppression woven throughout case vignettes, all against a backdrop of the heteronormativity that is ever-present in U.S. culture.

Martín-Baró writes "…the principle holds that the concern of the social scientist should not be so much to explain the world as to transform it" (1994, p. 19). With this in mind, we encouraged authors to focus on clinical work when revising or writing their chapters, hoping they would show what their clinical approach would look like when approaching their chapter's topic. Where possible, authors illustrated their clinical work with a line-by-line dialogue that can give the reader a reference point for implementing LGBTQIA-affirmative therapy into their own practice. In other cases, brief vignettes highlighting important concepts were included throughout the chapter. We asked for a clinical focus because we want to highlight the *practice* of affirmative therapy—what it can look like and sound like to chip away day after day, session after session at the oppressive narratives that dominate our lives and those of our clients. We believe that this is important, transformational work.

By intentionally muddying notions of boundaries and dichotomies, we have come to realize that the sections of this book are interconnected and not easily distinguishable. Ethical considerations appear in nearly all the chapters; clinical issues with couples are related to clinical issues with families; intercultural considerations impact sex therapy … hopefully, the overlapping nature of clinical issues, identity management, historical and political backgrounds, and patriarchy, racism, and heteronormativity is evident.

We strongly believe that the future of LGBTQIA-affirmative therapy is connected to an embrace of intersectionality, and a resistance against abuses of power inherent in the intersecting politics of racism, misogyny, and classism. We must—as Baldwin suggests—mature and evolve as we seek to move toward health and therefore toward justice. To accomplish this, we must resist false equivalences, challenge the training we received as professionals which advises us to remain "neutral," and deepen our critique of white supremacist, patriarchal dichotomies. This process is ongoing. We look forward to seeing continued evolution toward social justice for all.

References

Baldwin, J. (1985). *The price of the ticket: Collected nonfiction 1948–1985.* St. Martin's Press.
Martín-Baró, I. (1994). *Writings for a liberation psychology.* Harvard University Press.

Section I
Foundations of LGBTQ Affirmative Therapy

Taylor & Francis
Taylor & Francis Group
http://taylorandfrancis.com

1
Evolution of LGBTQ Affirmative Couple and Family Therapy

REBECCA HARVEY, MEGAN J. MURPHY and TRACEY A. LASZLOFFY

Queer author and essayist Carmen Machado describes (2019) the dilemma queer people face when attempting to understand, articulate or contextualize their own lives.

> the late queer theorist José Esteban Muñoz pointed out that "queerness has an especially vexed relationship to evidence…when the historian of queer experience attempts to document a queer past, there is often a gatekeeper, representing a straight present." What gets left behind? Gaps where people never see themselves or find information about themselves. Holes that make it impossible to give oneself a context. Crevices people fall into. Impenetrable silence.
>
> *(Machado, 2019, p. 18)*

Affirmative therapists enter those impenetrable silences to assist, but to be effective they must first unlearn lessons taught by predominantly western heteronormative cultures. In his critique of Western psychology, Martín-Baró (1994) writes:

> …the most serious problem of positivism is rooted precisely in its essence; that is, in its blindness toward the negative. Recognizing nothing beyond the given, it necessarily ignores everything prohibited by the existing reality; that is everything that does not exist but would, under other conditions, be historically possible.
>
> *(Martín-Baró, 1994, p. 21)*

The quotes provide a useful way to imagine the trajectory of affirmative therapy: where it has been and most especially where it must now position itself going forward.

Affirmative therapy emerged in the late 1980s and 1990s as a response to the widespread pathologizing of Lesbian, Gay, Bisexual, Queer, and Transgender or Gender expansive(LGBQ &TGE)[1] people in the mental health fields and society at large. Beginning mainly as a challenge to the assumption that homosexuality[2] was inherently disordered, it has been evolving ever since, mir-

[1] Terms used to describe people who are minoritized for diverse sexual orientation and gender identities are constantly evolving and increasingly nuanced. Umbrella terms are useful for honoring the connections and similarities which exist among this varied group of people, yet they are problematic when they are not specific enough or conflate identities that require separate focus. We do our best in this chapter of striking a balance between connection and conflation, honoring similarities without minimizing unique experiences. Throughout this chapter, we use a few alternate terms depending on the focus of our writing: *LGBTQ* refers to lesbian, gay, bisexual, transgender, and queer; *TGE* when referring more specifically to people who are transgender or gender expansive; *Queer as an umbrella term* to refer generally to those who are not cisgender or heterosexual.

[2] Homosexuality was a psychiatric diagnosis which subsequently became a popular cultural term used to describe same-sex sexual desire, behavior, and identity. We consider it an outdated word, based in pathology and therefore only use it when referring to its historical relevance.

DOI: 10.4324/9780429274626-3

roring shifting social attitudes (Giammattei & Green, 2012) to include gender-affirming therapies (Chang & Singh, 2016; Coolhart & Shipman, 2017; Lev, 2019) and a variety of methods and approaches which support the health and wellness of LGBTQ individuals, couples, and families (Johnson, 2012). As affirmative therapy continues to evolve, it must contend with (and be a part of) increasingly nuanced challenges to traditional, patriarchal, heteronormative white supremacist ideas of sexuality and gender (Singh, 2016). This includes contending directly with the same racist, sexist, heteronormative blind spots reproduced from the larger culture and then baked into its own construction. As individuals and families navigate multiple pathways to the development of healthy sexuality and gender identity, along with diverse constructions of intimate relationships, marriages, and families, it is imperative that clinicians are able to navigate outside of the traditional confines of a patriarchal, heteronormative gender binary. In particular, affirmative therapy must develop a truly intersectional lens (Addison & Coolhart, 2015), be intentionally anti-racist and anti-sexist in practice, and advocate for full inclusion of bisexual and transgender and/or gender-expansive (TGE) people.

This chapter begins by examining the historical context that gave rise to the need for an affirmative therapy. We acknowledge hierarchical societal forces that have shaped the mental health field in general, and the field of Marriage and Family Therapy (MFT) more specifically. We explain how these forces have constrained our comprehension of the complexity and fluidity of gender and sexuality, and by extension, have contributed to the marginalization and oppression of those who do not conform to traditional notions of gender and sexuality. We consider the field of MFT—founded in a challenge to the positivist, mechanistic worldview that has governed so much of modern psychological thought—and recommend it to fully extend its own systemic principles to examine and mitigate the effects of sociocultural injustice on individual mental health and family relations. We identify and discuss several issues that affirmative therapy must grapple with if it is to become truly affirming to all LGBTQ people.

The Sociocultural Context of Patriarchy and Hierarchical Dualism

At the core of Western society[3] is a patriarchal social organization which emphasizes individual agency separating the world accordingly into distinct oppositional entities such as light/dark, good/bad, spirit/flesh, mind/body, healthy/unhealthy, white/black, and of course, male/female. These polarities are arranged hierarchically with socially assigned differential values such that categories placed first are valued and regarded as superior, whereas categories placed second are devalued and regarded as inferior. With differential valuation comes differential power. It is this paradigm that enables and multiplies oppression by manipulating and controlling access to power allowing some to prosper at the expense of others (Frye, 1983). Patricia Hill Collins (2000) referred to this as "an intersecting system of oppressions" which interrelate and reinforce one another (p. X). Similarly, bell hooks (2004) uses the term "imperialist white supremacist capitalist patriarchy" (p. 17) to refer to the interlocking nature of systemic oppressions that "grant power and privilege to some, while disproportionately disadvantaging others" (Fitts, 2011, p. 112) on the basis of categorical separations such as race, gender, class, sexuality, nationality, and so forth.[4] These socially constructed classifications form the basis for a system of structural inequalities and interlocking oppressions which are justified by claims that these categorizations and inequalities exist independently and reflect immutable, universal differences.

[3] This chapter focuses exclusively on Western societies since this is the context we know best and practice in; however, it is important to acknowledge that the preponderance of human societies around the world are steeped in patriarchy.

[4] For our purposes, we will refer to these systems as White Supremacist Colonialist Patriarchy (WSCP) or simply interlocking systems.

A foundational tenet in the White Supremacist Colonialist Patriarchy (WSCP) paradigm is misogyny, which informs specific conceptualization and treatment of gender and sexuality. The social construction of gender as a "natural," essential binary conceives of males/masculinity and females/femininity as mutually distinct, oppositional, and complementary in nature (Butler, 1990; Fausto-Sterling, 2000; Rich, 1986). Historically, because men and masculinity are considered superior, they necessarily dominate over women who are considered inferior and in need of male guidance and protection, although men/masculinity may also be complemented by women/femininity. In this way, a hierarchy is constructed with males/masculinity valued and empowered over females/femininity which is devalued and disempowered.

Similarly, just as gender is constructed as a binary, sexuality is also similarly situated. Gender and sexuality are interwoven so that being a man/masculine requires sexual attraction toward and sexual behavior exclusively with women; likewise, being a woman requires sexual desire toward and sexual behavior exclusively with men. Heterosexuality is expected, elevated, and valued, while LGBQ sexualities are devalued and oppressed. If differences in access to power and privilege are to be maintained, they must be justified by a robust distinction between genders which in part is why heterosexuality is deemed compulsory. In other words, to ensure the maintenance of gender power imbalances, it is critical to sharply bifurcate gender which requires heterosexuality. Moreover, these binaries are then promoted and defended by (a) naturalizing traditional gender roles and imbuing these with exclusive meaning; (b) extolling the virtue of heterosexual marriage and nuclear family structures then providing exclusive significance and privileges to these traditional relationships; and (c) weaponizing heteronormativity and homophobia (Pharr, 1997) along with misogyny, white supremacy, and classism. It is within this societal context that the entire mental health system and the field of MFT have been formed.

The History of Gender and Sexuality in Mental Health

The mental health field was formed within racist, sexist, homophobic power structures that reflect WSCP values in society at large, and as a result modern psychology has legitimated these biases and reproduced them within its own theories and interventions. As Martín-Baró (1994) noted, "psychologizing has served, directly or indirectly, to strengthen the oppressive structures by drawing attention away from them and toward the individual subjective factors" (p. 19). One of the clearest examples of how this occurs within in the mental health system is with regard to psychiatric diagnoses that reinforce oppression by locating the source of dysfunction within individuals while focusing scant attention to the social context and forces which shapes their lives. An early example of this occurred in the 19th century with the fabrication of *Drapetomania*, a mental illness invented during slavery to pathologize the desire that enslaved people had to flee captivity; the framing of this diagnosis is centered in white supremacist ideology which locates the "problem" of running away as a deficit within the individual rather than within an oppressive system of slavery which any human being would wish to flee. Similarly, *hysteria* could be found in the Diagnostic and Statistical Manual of Mental Disorders (DSM) until its removal in 1980 (Tasca et al., 2012). As defined in the DSM, this diagnosis could only be applied to women and contained a range of vague symptoms, including anxiety, irritability, and sexual forwardness; any of these symptoms could better be understood in the context of what were unreasonable expectations of women in society—to be servile, ever pleasant, devoid of sexuality, and accepting of her place in the hierarchy.

The WSCP worldview inherent in the development of the DSM and the diagnoses within it conveniently ignores the dominant groups' access to power and the resultant impact on interpersonal relationships or society at large. By focusing on the individual victims rather than the perpetrators of oppression and violence, these disorders minimize the societal level power dynamics of relational domination which both normalizes perpetration by the oppressor group

and pathologizes the experience of domination by the oppressed group. The ability to determine what can be ignored thus ensures that these power dynamics remain effectively invisible, pervasive, and unchallenged. There is no DSM diagnosis appropriate to people who display racist, sexist, ableist, misogynistic behavior, despite the great damage done on an individual, family, and societal scale as a result of these beliefs.

Another example of the ways that the mental health field has buttressed patriarchy by pathologizing marginalized peoples can be found in the way the DSM has often confused sexual orientation and gender identity by conflating and problematizing any manifestations of these that violated patriarchal gender norms (Lev, 2013; Nealy, 2017). This conflation emerges from within the confines of patriarchy where biological sex, sociocultural gender, and sexual desire are inextricably connected. Arguably, what mainly unites lesbian, gay, bisexual, and transgender and gender expansive people is the way they transgress WSCP gender expectations. The facts of queer lives, their romantic/sexual relationships, and their families challenge and destabilize the gender binary and traditional notions about family life (Harvey et al., 2020). As such they share the experience of marginalization and oppression which occur as a result of these transgressions. It is these same heteronormative assumptions which first drove the diagnosis of homosexuality and was then later used to officially pathologize transgender people. As a result, there is a distinct yet parallel trajectory in how psychiatric diagnoses first progressed from "mental illness to human diversity" (Lev, 2013, p. 292), first for gay/lesbian people, and then for TGNC people.[5]

With the inclusion of homosexuality as a psychiatric diagnosis in the second edition of the DSM in 1968 (Burton, 2015), long-standing religious and cultural biases were legitimized under the cloak of science and objectivity which were used to police gender role expectations, sexual attraction, and behavior. In the following years, fueled by increasing social acceptance of LGBTQ people, the mental health fields would adopt, defend, revise, and abandon a series of mental disorders pertaining to sexual orientation and gender identity (Lev, 2013; Nealy, 2017). One of the early steps in this direction occurred in 1973 when the American Psychiatric Association (APA) reversed itself and removed homosexuality from the DSM. With this removal there was no official means within mental health fields to address still pervasive concerns about gender variant behavior among boys and men. Many in the medical and mental health fields persisted in searching for the etiology of homosexuality (Lev, 2013) and developed interventions to treat it and other gender-non-conforming behaviors (Nealy, 2017). For example, following the official removal of homosexuality from the DSM, a number of related diagnostic codes were developed, retained, and then revised, including *Ego-Dystonic Sexual Orientation* in the DSM-III (American Psychiatric Association, 1980), and in the DSM-IV-TR (American Psychiatric Association, 2000) a subcategory of *Sexual Disorders Not Otherwise Specified [NOS]* which described "Persistent and Marked Distress about Sexual Orientation" (p. 582).

The first diagnosis pertaining to gender identity was included in 1980 directly following the 1973 removal of homosexuality from the DSM. As a result, some in the LGBTQ community perceived that *Gender Identity Disorder* was created as an alternate path to discourage feminine gender expression, including gay identity among boys/men (Nealy, 2017). Conversely, some advocates for transgender people supported the creation of this diagnosis assuming that treatment and medical intervention would be developed only if a psychiatric diagnosis legitimized the need (Lev, 2013). Gender Identity Disorder endured through two additional revisions of the DSM and finally was revised in the DSM-5 to *Gender Dysphoria*. The intent in replacing "disorder" with "dysphoria" was to move away from language that focused on transgender identity being inherently pathological. Dysphoria instead emphasizes the role of distress which occurs

[5] See Lev (2013) for a more detailed discussion of the evolving interplay of the diagnoses related to sexual orientation and gender identity.

for some persons when their assigned birth is dissonant with their experienced or affirmed gender. Therefore, the problem lies less in the inherent identity of an LGBQ or TGNC person and more on the pathology created by what has subsequently come to be known as *minority stress* or the distress one feels from the stigma and shame that results from living in a heterosexist, heteronormative culture (Bowleg et al., 2003; Burton, 2015; Chen & Tryon, 2012; Levitt & Ippolito, 2014). These revisions are important progressions for TGNC health and wellness (Nealy, 2017) yet, despite progress, the latest iteration of the DSM (American Psychiatric Association, 2013) continues to pathologize and stigmatize TGNC people. As Nealy (2017) pointed out:

> At the root of this stigma is the fact that gender dysphoria (and its predecessor gender identity disorder) is a psychiatric, not a medical diagnosis. The fact that the diagnosis is located within the DSM labels it as a mental illness. Consequently, all transgender people who desire to medically transition must assume the stigma of being diagnosed as mentally ill.
>
> *(p. 24)*

Outside of this gender binary, many genders and sexualities are possible, but the mental health field has struggled to see anything outside of what WSCP assumptions and social tolerance would allow (Giammattei & Green, 2012). The diagnostic codes reflect and often weaponize the WSCP cultural view of individuals who live outside of heteronormativity. Confined by WSCP assumptions about a gender binary, mental illness is the only available language which can explain how someone can feel dissonance between their assigned sex at birth (usually connected with physical genitalia) and their internal experience of gender (Nealy, 2017), just as it was previously the only way to explain sexual desire for someone whose assigned sex is the same as one's own, or before that to explain why an enslaved person would want to escape or why a woman might desire sex or often feel irritable and angry.

LGBTQ people were originally seen and treated as a monolith, aggregated together for the ways they transgressed patriarchy (Harvey et al., 2020) with the differences between them—including gender identity, sexual orientation, race, ethnicity, and class—routinely not addressed. The result was a racist, sexist, heterosexist view that often erased bisexual and especially TGNC people altogether just as it overemphasized white, middle-class, male worldviews. There has been a slow progression on the part of mental health systems to depathologize, and begin to see, know, and understand this varied group on their own terms.

Gender and Sexuality in Marriage and Family Therapy

When family therapy emerged in the 1950s, it resisted conventional ways of conceptualizing, diagnosing, and treating mental illness which emphasized the individual as the site of both pathology and intervention. Instead, MFT emphasized family relationships, pattern, and process in order to understand how human behavior makes sense in a larger context. Based on the systemic assumption that all parts of a system are interrelated, symptoms in one member of a system indicated something about health and wellness of the entire system. As a result, systemic therapists broadened treatment to include the entire family system. The paradigm shift from an individual to a family focus was revolutionary at the time and it brought forth creative new treatment options and viewed mental illnesses as a problem often developed and maintained within relational dynamics rather than being located within the individual.

MFT as a field still proudly embraces this systemic paradigm shift from an individual, linear view to a holistic, systems approach, and it uses this shift to distinguish itself from other mental health professions. While family therapy convincingly expanded mental health from an individual to a family focus—and was well positioned to question the WSCP status quo—the systemic conceptualization

generally stopped there. The field operated in a self-congratulatory fashion for several decades until feminists began pointing out the lack of attention to the dynamics of power that regulated family relations as well as the effect of this on women and other vulnerable members of the system.

Reinforcing the Gender Binary

Until the 1980s, much of the MFT field failed to address considerations of power that occur at the societal level and then affect individuals and families. For example, the field has effectively failed to address highly politicized terms "marriage" and "family" that appear in the field's moniker, which have repeatedly been—and continue to be—used to advance a conservative agenda at the expense of LGBTQ people. Various feminist scholars beginning in the late 1970s warned against this pointing out how (a) therapeutic neutrality in the face of power imbalances maintained and promoted a patriarchal status quo that was often oppressive and sometimes violent; (b) how women's roles and oppression were overlooked in classic therapy theories; and (c) how foundational MFT theories tended to reinforce traditional gender roles and male dominance (Avis, 1985; Brown, 1986; Walsh & Scheinkman, 1989; Walters et al., 1988). In her influential article published in *Family Process* in 1978, Rachel Hare-Mustin highlighted how the field of family therapy, despite its purported focus on systems, lacked the perspective to account for its own gender assumptions and therefore failed to contextualize women's experiences. Mothers were blamed for causing mental illnesses (including schizophrenia and homosexuality) in their children by being overly involved and lacking differentiation or healthy communication skills (Bograd, 1990). Moreover, women and women's roles were repeatedly minimized and pathologized. Hare-Mustin (1978) noted that structural family theory openly emphasized and promoted enforcement of parental hierarchies in which fathers are expected to exert leadership and exhibit control of the entire family, including their wives. Similarly, Bowen's family systems approach elevated independence, rationality, emotional repression, and self-control as markers of health (Avis, 1998; Walsh & Scheinkman, 1989). It was no coincidence that differentiation (i.e. health) was associated with characteristics reserved for an idealized masculinity. Hare-Mustin asserts that "Bowen's Differentiation of Self Scale can readily be identified as a sex stereotyped masculinity-femininity scale with femininity at the devalued end" (Hare-Mustin, 1978, p. 2).

One consequence of the failure to recognize the influence of social context on family theories of health and pathology has been the wholesale acceptance of traditional gender role expectations and corresponding WSCP definitions of marriage and family which profoundly affect everything that comes after, especially intimacy. Under patriarchy, everyone is denied the full spectrum of humanity. Oppression is a double bind which means that for oppressed groups, "you're damned no matter what you do." Men—white men specifically—can assume a way of being in the world that leads to some measure of valuation and power even though they suffer by virtue of having to deny their vulnerability. For women, no matter what, the result is devaluation and mistreatment. Hence, if women follow the script, they accommodate to oppression, diminish themselves, and are judged as weak. If they defy it, they are judged harshly as bossy or bitchy. Multiply this oppression exponentially for those who also experience oppression based on race, age, sexuality, and class.

Despite some progress, the field's treatment of power, gender, and sexuality continues to replicate the invisibility of these critiques within the larger society. The feminist critique itself while revelatory was limited by its "single-axis framework" (Crenshaw, 1989, p. 140) wherein it reflected dominant white (women's) voices that appeared to speak for all women. In making the same mistake that systems theory did—challenging parts of the status quo while upholding the larger patriarchal, racist ideas—white feminists effectively marginalized the voices of Black and Brown women whose oppressive experiences as women could not be understood separate from their oppressive experiences as racially minoritized women (Crenshaw, 1989).

Inching toward Intersectionality

Slowly, feminist critiques led to increased acknowledgment that differential access to power affected interpersonal and intimate relationships. This, in turn, provided credibility to the concerns of other marginalized groups that were being widely ignored in the field. In the late 1980s, family scholars' writings about race began to be published with more frequency (Boyd-Franklin, 1984, 1987; Hardy & Laszloffy, 1994, 1995, 1998), challenging the white-centeredness of the field, including the feminist thinkers who had not accounted for race and racial power in their critiques (Hardy & Laszloffy, 1994, 1995, 1998; Laszloffy & Hardy, 2000). Still, these writings for many years were considered outside the mainstream white narrative of the family therapy field. A similar surge of writings about sexual orientation emerged in the 1990s, with several notable articles that introduced the idea that sexual orientation might be important for family therapists to consider (Clark & Serovich, 1997) which was followed by a flurry of writing regarding TGNC in the 2010s (Connolly et al., 2016; Coolhart & Shipman, 2017; Giammattei, 2015; Lefevor et al., 2019; Leland & Stockwell, 2019; Malpas, 2011; Porter et al., 2016; Singh, 2016; Singh & dickey, 2017). In writing about each of these critical areas—race, sexual orientation, gender—there was a need to differentiate one group from the other; that the challenges LGBTQ people face, for example, are different from those cisgender, heterosexuals face because of their different places in societal hierarchy and the power each group had access to in their lives. To advance these issues meant necessarily highlighting each in a binary way which magnified differences between groups in order to make them accessible for exploration. Scholarly work about oppressed groups was framed in isolation from other marginalized groups. On the one hand, these writings importantly challenged white men's experiences as the standard norm. On the other hand, they upheld the status quo by adhering to a pattern of universalizing "us-versus-them" contrast that neglects the overlaps and commonalities between groups. So important nuances of identity were rarely considered, for example, how identifying as both racially minoritized and LGBTQ dramatically altered one's experience of both identities; or how one might be TGNC and also lesbian or gay and how these coinciding experiences affected family life. As each "category" of concern was written and addressed, we slowly began to understand not only that identity shapes who we are, but that they are not separate parts of ourselves—rather, they intersect in particular ways that shift over time as well as shift as we engage in particular relationships; this all takes place within a larger sociopolitical cultural context that influences how our particular identities have access to power or not.

Intersectionality as a concept is grounded in Black feminists' work and has evolved over time. Curtis et al. (2020) offer the following definition:

> Intersectionality as a means of describing how broad social categories such as race, gender, and class, along with more specific social categories, such as an 'essential worker,' for example, interacts with interdependent systems of privilege, discrimination, and disadvantage to influence the lived experiences of individuals, families, and communities.
>
> *(p. 513)*

The definition underscores the overlapping nature of multiple systemic oppressions experienced by individuals based on social categories associated with one's identity.

Pathologizing Homosexuality, Reinforcing Heteronormativity

Like other mental health disciplines, MFT was so soundly steeped in heteronormativity that originally it could only accommodate the existence and experience of LGBTQ people by pathologizing them along with their family systems (Giammattei & Green, 2012; Hatterer, 1970; LaSala, 2013). Giammattei and Green noted that foundational systemic theories are filled with

microaggressions toward LGBTQ people (Giammattei & Green, 2012), which Sue (2010) noted are often unintentional thoughts or actions rooted firmly in oppressive assumptions about minoritized peoples. In this case, the most important founders of systemic thinking felt entitled to widely and openly pathologize "homosexuals" and blame dysfunctional family systems for producing homosexual offspring. At the same time, white male sexuality was unselfconsciously centered so that gay men became particular targets of disdain (Giammattei & Green, 2012), scorned for their effeminacy or for other transgressions of masculinity which made them more like women and therefore inferior, while women's (homo)sexualities were so irrelevant as to not even be a serious consideration and were routinely minimized or ignored.

Problematizing LGBTQ Identity

Following the removal of homosexuality as a psychiatric diagnosis, family theorists, mirroring the culture around them, began to shift away from focusing on disordered identities and instead focused on the problems that family systems faced by virtue of having a member with an LGBTQ identity. Gradually, case studies were offered up in mainstream family therapy journals which included same-sex couples, heterosexual partnerships where one party (usually the husband) was in the process of coming out, or parents seeking help when their child was coming out (Giammattei & Green, 2012). The central focus of this work was on "the problem" of LGBTQ identity and on managing the negative impact of it on couples and families (Hudak & Giammattei, 2014; LaSala, 2013; Stone Fish & Harvey, 2005). This meant that when LGBTQ lives were represented in clinical work, their LGBTQ identity was emphasized as the source of mental health problems. While this was less pathologizing than a label of mental illness, it continued to locate the problem within an individual or perhaps a family.

Moreover, these case studies were presented using theories and interventions not developed to specifically consider or include LGBTQ experience and by clinicians who rarely if ever extended their systemic assessment to include their own inherent bias. So even if they cared to, they could not alter their theories to better accommodate LGBTQ identity or people, nor certainly could they imagine that in so doing they might actually improve upon their original theories. The cumulative effect was to underemphasize the role of more universal couple and family problems within LGBTQ lives while overemphasizing the universality of family therapy treatments dominated by heteronormative discourse. Giammattei and Green (2012) wrote, "This is evidenced by the frequency with which the concepts of marriage, couple, and family are used in research, theory, training, and conference presentations without specifically naming heterosexuality, even though heterosexuality seems the taken-for-granted reference point in these contexts" (p. 5). The culmination of all of this is the continued marginalization of LGBTQ lives as heteronormative standards are repeatedly reinforced with the assumption that couples, families, marriages, husbands, and wives belong universally to heterosexuals and heterosexuality.

LGBTQ People Studied as a Monolith

As previously discussed, queer experiences of gender and sexuality were problematized and conflated by the culture at large and then interwoven into the mental health system within both treatments and diagnoses. With the gradual shifting of attitudes came increased recognition that LGBTQ people faced unique stressors. Theorists and clinicians—rightfully so—became interested in understanding the unique experiences that LGBTQ people shared. But the pattern of conflation persisted and LGBTQ individuals, couples, and families were studied as if they were a monolithic category, as if all LGBTQ experience was easily summarized against the enormous presence of cisgender, heteronormative (white, Judeo-Christian) experience. While indeed there were and are important differences between cisgender, heterosexual experience and LGBTQ experience, the entirety of LGBTQ experience is not so easily summarized without employing an intersectional

understanding (Singh, 2016). This lack of contextual understanding had the effect of emphasizing the similarities between all gender and sexual minorities while minimizing the differences in their lived experiences. The coming out process, family of origin relationships, and couple dynamics were studied as if all non-heteronormative people were similar enough to generalize about without taking into consideration all the ways they were different (Harvey et al., 2020). While shared experiences of oppression served at times to unite LGBQ with TGNC people (e.g. the Stonewall riots), it has been a lopsided, unequal, and sometimes uneasy alliance with some identities (TGNC, bisexual, and the experience of Black and Brown LGBTQ people) getting short shrift and little attention. The view of LGBTQ people created even in affirmative therapy and theory has centered on the experience of white, relatively wealthy, educated men, and women since it is these people who are historically mostly likely to be in the empowered positions to theorize, write, and publish. Lost is the intersectional nuance of genders and sexualities created and expressed through a diverse spectrum of salient identity markers such as race, ethnicity, class, and immigration status.

Considering Race

Similar to the way heterosexuality is centered and routinely amplified, whiteness has been centered in all constructs related to family and relationships. This happens pervasively and often indirectly and hence is rarely named or acknowledged. The preponderance of scholarly work addressing "LGBTQ Families" does not name race except when referring to people of color. Hence, when race is not named, the subjects are almost always white (Hardy & Laszloffy, 1994). Family science and family therapy all routinely fail to account for race in meaningful ways, giving privilege to white accounts and experiences of the way family ought to be. Writings about race, racism, and the impact of slavery, Jim Crow and chronic discrimination are still scarce in the family studies field. Addressing race is seen as a layer to address *after* one understands family rather than a more nuanced approach which understands one cannot be separated from the other. Finally, while recognizing the impact of minority stress on the lives of minoritized people has been a step in the right direction in the fields of Family Science and MFT, doing so while remaining neutral, disinterested, and uncommitted to more fundamental second order change continues a systemic pattern of focusing change within individuals and families who are forced to accommodate oppression for survival.

Affirmative Family Therapy

A specific definition of affirmative therapy has been difficult to elucidate since its inception in the 1980s. Johnson (2012) noted the lack of clarity about whether affirmative therapy is a theoretical approach or a set of specific intervention(s). Beginning with an exclusive focus on sexual orientation, there has been a wide array of loosely connected affirmative methodologies which eventually were adapted to address gender identity as wider cultural acceptance has evolved. Harrison (2000) conducted a thematic analysis and surmised that affirmative therapy was originally marked by a non-pathological view of homosexuality and some level of knowledge on the part of the therapist about the experience of people with same-sex desire. Harrison also noted that a few articles mentioned advocating for clients specifically and LGBTQ people generally by challenging societal oppression. Ritter and Terndrup (2002) loosely defined affirmative therapy as being characterized by therapists who (a) are accepting of homosexuality as part of natural human variation; (b) are reasonably free of heterosexist bias and prejudice; (c) have a working understanding of gay, lesbian, and bisexual experience; and (d) possess a willingness and capacity for self-examining how they themselves are influenced by heterosexism (Ritter & Terndrup, 2002, pp. 1–2).

Affirmative care was broadened to specifically address transgender experience, including gender-affirming therapies which Coolhart and Shipman (2017) characterized as "therapy which assumes that transgender and gender-nonconforming identities are natural variations of

humanity that should be normalized and affirmed" (p. 113). Singh (2016) expanded on the idea to include self-reflection on the part of the therapists regarding their gender bias and assumptions, as well as paying special attention to intersectional issues and identities relevant for TGNC people.

At a minimum, affirmative therapies all take a non-pathologizing stance toward gender and sexual diversity and toward LGBTQ identity. Affirmative therapists must be willing to thoroughly examine all components of treatment for the messages they send to and about LGBTQ people (Hadland et al., 2016), as well as understanding that the source of any pathology is rooted within a dysfunctional social context that devalues and discriminates against those who are LGBTQ rather than inherently within LGBTQ people themselves.

Actions in Support of the Evolution of Affirmative Therapy

The following section discusses our ideas for how affirmative therapy needs to evolve and expand so it remains relevant, best meets clients' needs, and affirms the interests and identities of all people, especially those who are LGBTQ in our rapidly changing world.

Center Ethics and Intersectionality The highly questionable ethics regarding how LGBTQ people have historically been treated by the mental health fields are instructive examples about how considerations of power and influence create huge blind spots in ethical codes which persist even to this day (see Chapter 3). Historically, the mental health response has been to locate pathology within the individual and ignore societal level dysfunction and oppression (Martín-Baró, 1994). Even the MFT field, primed as it is to discern systemic interactions, has often failed to see its own position and homeostatic function within the WSCP power structures. Affirmative therapy was necessitated by the inability to discern unjustifiable power imbalances and the multiple, intersecting instances of oppression this reproduces at the societal level and within intimate family relationships. The need to attend to intersectionality arises from the WSCP roots of the U.S. (and other countries colonized by imperialist white Europeans), and the way that these values are baked into the practice of psychotherapy, broadly defined. Martín-Baró (1994) notes that these biases are inherent when a field advocates for its access to influence within an oppressive power structure, which requires a contribution to the status quo that limits the ability to then challenge that status quo. Yet, we have an ethical responsibility, rooted in a communal sense of care and concern for others, to locate our focus of analysis on larger structures and manners of domination if we are to have any hope of effecting long-lasting, meaningful change beyond the therapy room. Great strides have been made toward justice, and now with a clear illustration of exactly how our theories, ethical codes, and even leaders in the field can fail us and more importantly our clients, it is incumbent upon us to address this failure.

Intersectional Clinical Work What has become clear in the last decade or so is that LGBTQ people and families are diverse and complex. But affirmative therapy has suffered from a lack of intersectionality creating large gaps in understanding the experience of people at the crossroads of multiple oppressions. While there are important patterns and similarities, there is no universal LGBTQ experience. Oppression is reinforced, recreated, and experienced through unique interactions of race, class, gender, sexuality, religion as well as individual personality and family dynamics. If affirmative therapy is to be actually affirming to *all* LGBTQ people, it must welcome and address the full intersectionality of LGBTQ experience. Therapists must become adept at understanding how current sociocultural political systems undermine all LGBTQ families and to intervene differently and specifically based on these intersections.

One gap that must be addressed in affirmative therapy is race that, like gender, is a foundational dimension of diversity and shapes all aspects of our lives. We live in a racially segregated

society, and depending on our racial location, there are dramatic differences in our access to power, resources, and valuation. LGBTQ people of color comprise nearly 22% of people in same-sex relationships and they experience unique manifestations of microaggressions because of their multiple marginalized identities as sexual, gender, and racial minorities (Balsam et al., 2011; Bowleg et al., 2003; Chen & Tryon, 2012; Levitt & Ippolito, 2014). Additionally, LGB people are more likely to enter into interracial relationships, have had more interracial romantic partnerships, and have more racially diverse community connections than cisgender heterosexual people (Horowitz & Gomez, 2018). Hence, the experiences of LGBTQ people who are white differ from those who are people of color. This difference matters and needs to be continually acknowledged and addressed directly in affirmative therapy scholarly work (das Nair & Thomas, 2012) through (a) intentional resistance of a monolithic presentation of LGBTQ families; and (b) exploring and naming race (especially whiteness) in case studies, research, supervision, and case presentations.

Class is another variable that warrants consideration when examining the experiences of LGBTQ persons. Given that LGBTQ people have lower incomes and higher levels of poverty than corresponding cisgender, heterosexual people (Badgett et al., 2019), it is especially important to factor class location into our assessment of the experiences of LGBTQ persons and to have particular sensitivity to the ways that being poor or working class is uniquely stressful. This is even more important given that in the U.S., there is a widening economic disparity coupled with a tendency to privilege the interest of the upper or middle classes while minimizing class differences and either ignoring or blaming the poor for their own economic distress. The burden of shame multiplies for the LGBTQ person who is also struggling financially. Hence, efforts to understand the experiences of LGBTQ persons must include a consideration of class as a powerful organizing principle and the burden of multiple stigmatized identities that increase the likelihood of shame. Like with race, when class is unnamed, the experiences and expectations of middle- and upper-class lives are centered.

In short, LGBTQ people and families are not a monolith and cannot be effectively understood as such. Affirmative therapists must get better at understanding how pressures of interlocking systems of domination at the macro level are being expressed at the micro level of intimate relationships. Affirmative therapists must be mentored to capably name intersectional differences, track how power differentials based on these differences manifest themselves within families, and be able to tailor treatments rather than rely on those standardized on WSCP norms to intervene and build protection against oppression.

Challenge the Gender Binary As discussed previously, WSCP dominance demands the preservation of a sharply divided construction of gender that clearly defines who/what is or is not "a man." Human beings are more fluid and non-binary than can be easily understood within the limitations of our current sociopolitical social constructs (Diamond, 2003; Zoeterman & Wright, 2014). This rigid gender binary interferes with our ability to grasp the complexity and fluidity of gender, thereby inhibiting our ability to freely see and experience the full range of possible ways of being. To build therapeutic alliances which honor evolving identities requires a willingness to see what is difficult to see, given the filter of heteronormativity and to then ask how clients see and name their own lives and experiences (Harvey et al., 2020).

Moreover, it is important to recognize that the gender binary—amplified and sometimes weaponized as it is—constrains everyone's ability to freely participate and fully express the range of human experience and emotion (Giammattei, 2015; Harvey et al., 2020). This inhibits intimacy (Knudson-Martin & Mahoney, 2009; Real, 2002) and profoundly affects family life (Knudson-Martin & Laughlin, 2005; Real, 2007) for everyone, no matter how one identifies

their gender or sexuality. Affirmative therapy need not challenge whether general differences exist between men and women. Rather, it needs to challenge (a) the overemphasis placed on these differences; (b) the minimizing of differences between men as a group and women as a group; and most importantly (c) the devaluing of these differences.

Consider Language One way of challenging the gender binary is to carefully consider and rethink our use of language. The ever-expanding number of labels for queer identities (lesbian, gay, bisexual, transgender, queer, questioning, intersex, asexual and pansexual) makes sense "… because we are attempting to use heteronormative ideas to categorize human experience which often fall outside of these constructs and therefore resists these attempts" (Harvey et al., 2020, p. 545). Despite current positive cultural shifts and increase in available literature, society at large and the field of MFT continue to rely on language that reinforces the gender binary rather than imagine a gender spectrum.

As part of resisting the gender binary, affirmative therapy must resist conflating experiences of LGBTQ people and instead fully explore the singularity of each identity and even more specifically, each client's unique experience of that identity. Inclusion for groups who have been so pervasively marginalized cannot be assumed or taken for granted. For example, even when the terms *transgender* and *bisexual* have been included in the titles of articles and chapters, often they are not sufficiently addressed in the text or, when included, were assumed to be the same as the lesbian and gay experience. Multiply that for TGNC people of color whose life experiences have been rarely centered in mental health literature. We need to focus on these terms and fully explore identity with a critical consciousness that facilitates deconstructing the gender binary and the systemic oppression which underpins it.

Focus on Training Affirmative therapy family therapists must be adequately mentored and trained using practices which include (a) increased interaction with LGBTQ people (including faculty, supervisors, students, and clients), topics, and LGBTQ experiences (Godfrey et al., 2006); and (b) examining the influence of heterosexist or heteronormative beliefs and attitudes on the self of therapist (Long & Serovich, 2003). Carlson et al. (2013) found that there was a positive relationship between exposure to these training techniques, along with mentorship by supervisors who took an affirmative stance, and MFT students' increased sense of competence with LGBTQ clients. Although a study by Rock et al. (2010) found a majority of MFT students reported not having received any training of this kind, a later study by McGeorge and Carlson (2016) which surveyed faculty from MFT programs found a majority of faculty reporting affirmative stances in their own beliefs and within the curriculum of their MFT programs, suggesting that the field was progressing along with the wider culture.

Self of the Therapist Work An essential component of the evolution of affirmative therapy involves therapists being committed to self-examination. We are all socialized in a culture marked by domination and separation; hence, we all absorb the misogynistic, racist, classist, elitist, heterosexist, homophobic messages and are constrained by them in our personal as well as our professional lives. Power often invites those with privilege (and we all have some measure of privilege) to rush for a resolution of what feels uncomfortable or to feel overwhelmed with paralysis. Neither is very useful. It is incumbent upon each of us to examine and critique ourselves, and allow others to also examine and critique us, as a way of mitigating the power that we exact in relationships. We are likely to only see our lack of power through our experiences of oppression and marginalization. We need to welcome accountability by engaging in relationships with people who risk challenging our privilege and the power we have as a result of that privilege.

Affirmative therapy is not a destination to rush toward or arrive at. Truly becoming more affirmative requires an intentional effort to reject paralysis and non-action and to become aware of the power we hold that is both related to our individual identities and given authority by the larger sociocultural political landscape; we need to risk that power by being vulnerable in relationship, exhibiting humility in the lack of knowledge that we truly possess, and seek comfort and security knowing that we will always be learning. To do so is to embrace activism and to resist the pull of dominant discourses that put forward racism, sexism, classism, all wrapped in colonialism. This is the future of affirmative therapy; it is the future of all therapies that embrace social justice.

Summary

Affirmative therapy emerged in the 1980s and 1990s as a direct challenge to widely held heteronormative biases in the mental health fields. It was necessitated by the inability or unwillingness to consider the undue influence of power on the mental health system which itself emerged from sociocultural paradigms characterized by domination, misogyny, white supremacy, and colonialism. Oppression in all forms is derived from and reinforced by these interlocking systems of domination whereby living beings are divided into rigid categories that maintain an unequal access to power and resources. This domination has had destructive effects on all people but certainly on LGBTQ people who inherently threaten the binaries of gender and sexuality that much of this paradigm rests on.

Family therapy had some success challenging decontextualized, individualistic notions of mental health; however, it did not go far enough to represent LGBTQ people's lived experiences and relationships. Affirmative therapy has challenged the decontextualization of queer people and has fostered the creation of therapeutic spaces wherein LGBTQ people might be met, understood, and known on their own evolving terms. But as originally developed, affirmative therapy is necessary but not sufficient for the world into which we are heading: a world of increasing polarization, naked economic disparity, increasingly brazen racial injustice, and a bevy of alternate facts designed to muddy the waters and protect the status quo.

Incorporating intersectionality is still very new to the field (Addison & Coolhart, 2015). That we have not made more significant movement recognizing and attending to larger socio-cultural-political contexts within affirmative therapy speaks to the intractable power dynamics at play in maintaining the WSCP status quo. The field is still dominated by wealthy white male voices (and now white female voices). Until the mantle of leadership fully includes marginalized peoples—those of color and those who are LGBTQ—making this same mistake will be hard to avoid.

Going forward, the practice of affirmative therapy must directly challenge relational domination by supporting LGBTQ individuals and families to recognize and mitigate systemic abuses of power while affirming their own strength, beauty, and necessity. What might be possible in the absence of pervasive heteronormativity? Or pervasive sexism or racism? We do not yet know. What affirmative therapy looks or sounds like is evolving today in clinics, classrooms, and supervision sessions. We look forward to seeing its continued evolution.

References

Addison, S. M., & Coolhart, D. (2015). Expanding the therapy paradigm with queer couples: A relational intersectional lens. *Family Process, 54*(3), 435–453. https://doi.org/10.1111/famp.12171

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.). American Psychiatric Association.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). American Psychiatric Association.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Association. https://doi.org/10.1176/appi.books.9780890425596

Avis, J. M. 1998. Commentary: Does neutrality neutralize feminist awareness? A feminist response to Scheel and Ivey. *Contemporary Family Therapy*, 20: 323–331.

Avis, J. M. (1985). The politics of functional family therapy: A feminist critique. *Journal of Marital and Family Therapy, 11*(2), 127–138. https://doi-org.pnw.idm.oclc.org/10.1111/j.1752-0606.1985.tb00601.x

Badgett, M. V. L., Choi, S. K., & Wilson, B. D. M. (2019). *LGBT poverty in the United States: A study of differences between sexual orientation and gender identity groups.* https://williamsinstitute.law.ucla.edu/publications/lgbt-poverty-us/

Balsam, K. F., Molina, Y., Beadnell, B., Simoni, J., & Walters, K. (2011). Measuring multiple minority stress: The LGBT people of color microaggressions scale. *Cultural Diversity and Ethnic Minority Psychology, 17*(2), 163–174. https://doi-org.pnw.idm.oclc.org/10.1037/a0023244

Bograd, M. (1990). Scapegoating mothers: Conceptual errors in systems formulations. In M. P. Mirkin (Ed.), *The social and political contexts of family therapy* (pp. 69–87). Allyn & Bacon.

Bowleg, L., Huang, J., Brooks, K., Black, A., & Burkholder, G. (2003). Triple jeopardy and beyond: Multiple minority stress and resilience among black lesbians. *Journal of Lesbian Studies, 7*(4), 87–108. https://doi.org/10.1300/J155v07n04_06

Boyd-Franklin, N. (1984). Issues in family therapy with Black families. *The Clinical Psychologist, 37*(2), 54–58. https://doi.org/10.1037/e545332009-004

Boyd-Franklin, N. (1987). The contribution of family therapy models to the treatment of Black families. *Psychotherapy: Theory, Research, Practice, Training, 24*(3S), 621–629. https://doi.org/10.1037/h0085760

Brown, L. S. (1986). Confronting internalized oppression in sex therapy with lesbians. *Journal of Homosexuality*, *12*(3–4), 99–107. https://doi-org.pnw.idm.oclc.org/10.1300/J082v12n03_09

Burton, N. (2015, September 18). *When homosexuality stopped being a mental disorder.* https://www.psychologytoday.com/us/blog/hide-and-seek/201509/when-homosexuality-stopped-being-mental-disorder

Butler, J. (1990). *Gender trouble: Feminism and the subversion of identity.* Routledge.

Carlson, T. S., McGeorge, C. R., & Toomey, R. B. (2013). Establishing the validity of the affirmative training inventory: Assessing the relationship between lesbian, gay, and bisexual affirmative training and students' clinical competence. *Journal of Marital and Family Therapy, 39*(2), 209–222. https://doi.org/10.1111/j.1752-0606.2012.00286.x

Chang, S. C., & Singh, A. A. (2016). Affirming psychological practice with transgender and gender nonconforming people of color. *Psychology of Sexual Orientation and Gender Diversity, 3*(2), 140–147. https://doi.org/10.1037/sgd0000153

Chen, Y. C., & Tryon, G. S. (2012). Dual minority stress and Asian American gay men's psychological distress. *Journal of Community Psychology, 40*(5), 539–554. https://doi.org/10.1002/jcop.21481

Clark, W. M., & Serovich, J. M. (1997). Twenty years and still in the dark? Content analysis of articles pertaining to gay, lesbian, and bisexual issues in marriage and family therapy journals. *Journal of Marital and Family Therapy, 23*(3), 239–253. https://doi-org.pnw.idm.oclc.org/10.1111/j.1752-0606.1997.tb01034.x

Collins, P. H. (2000). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment.* Routledge.

Connolly, M. D., Zervos, M. J., Barone, C. J., II, Johnson, C. C., & Joseph, C. L. M. (2016). The mental health of transgender youth: Advances in understanding. *Journal of Adolescent Health*, *59*(5), 489–495. https://doi-org.pnw.idm.oclc.org/10.1016/j.jadohealth.2016.06.012

Coolhart, D., & Shipman, D. L. (2017). Working towards family attunement: Family therapy with transgender and gender nonconforming children and adolescents. *Psychiatric Clinics of North America, 40*(1), 113–125. https://doi.org/10.1016/j.psc.2016.10.002

Crenshaw, K. W. (1989). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory, and antiracist politics. *University of Chicago Legal Forum, 189*, 139–167.

Curtis, M. G., Ellis, É. M., Ann, S., Dai, Y., & Bermúdez, J. M. (2020). Intersectionality within family sciences and family therapy journals from 2010 to 2020. *Journal of Family Theory and Review, 12*(4), 510–528. https://doi-org.pnw.idm.oclc.org/10.1111/jftr.12399

das Nair, R., & Thomas, S. (2012). Race and ethnicity. In R. das Nair & C. Butler (Eds.), *Intersectionality, sexuality and psychological therapies: Working with lesbian, gay, and bisexual diversity* (pp. 59–88). BPS Blackwell. https://doi.org/10.1002/9781119967613.ch3

Diamond, L. M. (2003). What does sexual orientation orient? A biobehavioral model distinguishing romantic love and sexual desire. *Psychological Review, 110*(1), 173–192. https://doi-org.pnw.idm.oclc.org/10.1037/0033-295X.110.1.173

Fausto-Sterling, A. (2000). *Sexing the body: Gender politics and the construction of sexuality.* Basic Books.

Fitts, M. (2011). Theorizing transformative revolutionary action: The contribution of bell hooks to emancipatory knowledge production. *The CLR James Journal, 17*(1), 112–132. https://doi.org/10.5840/clrjames20111718

Frye, M. (1983). *The politics of reality: Essays in feminist theory.* Crossing Press.

Giammattei, S. V. (2015). Beyond the binary: Trans-negotiations in couple and family therapy. *Family Process, 54*(3), 418–434. https://doi.org/10.1111/famp.12167

Giammattei, S. V., & Green, R. -J. (2012). LGBTQ couple and family therapy: History and future directions. In J. J. Bigner & J. L. Wetchler (Eds.), *Handbook of LGBT-affirmative couple and family therapy* (pp. 1–24). Routledge.

Godfrey, K., Haddock, S. A., Fisher, A., & Lund, L. (2006). Essential training components of curricula for preparing therapists to work with lesbian, gay, and bisexual clients: A Delphi study. *Journal of Marital and Family Therapy, 32*(4), 491–504. https://doi.org/10.1111/j.1752-0606.2006.tb01623.x

Hadland, S. E., Yehia, B. R., & Makadon, H. J. (2016). Caring for lesbian, gay, bisexual, transgender, and questioning youth in inclusive and affirmative environments. *Pediatric Clinics of North America, 63*(6), 955–969. https://doi.org/10.1016/j.pcl.2016.07.001

Hardy, K. V., & Laszloffy, T. A. (1994). Deconstructing race in family therapy. *Journal of Feminist Family Therapy, 5*(3/4), 5–33. https://doi.org/10.1300/J086v05n03_02

Hardy, K. V., & Laszloffy, T. A. (1995). Therapy with African Americans and the phenomenon of rage. *In Sessions: Journal of Psychotherapy, 1*(4), 57–70.

Hardy, K. V., & Laszloffy, T. A. (1998). Pro–racist ideology and its implications for family therapy practice. In M. McGoldrick (Ed.), *Re-visioning culture and family therapy* (pp. 118–128). Guilford.

Hare-Mustin, R. T. (1978). A feminist approach to family therapy. *Family Process, 17*(2), 181–194. https://doi-org.pnw.idm.oclc.org/10.1111/j.1545-5300.1978.00181.x

Harrison, N. (2000). Gay affirmative therapy: A critical analysis of the literature. *British Journal of Guidance & Counselling, 28*(1), 24–53. https://doi-org.pnw.idm.oclc.org/10.1080/030698800109600

Harvey, R., Stone Fish, L., & Levatino, P. (2020). Sexual identity development and heteronormativity. In K. S. Wampler & L. M. McWey (Eds.), *The handbook of systemic family therapy* (Vol. 2, pp. 541–569). Wiley. https://doi.org/10.1002/9781119438519.ch55

Hatterer, L. J. (1970). *Changing homosexuality in the male: Treatment for men troubled by homosexuality.* McGraw-Hill.

hooks, b. (2004). *The will to change: Men, masculinity, and love.* Washington Square Press.

Horowitz, A. L., & Gomez, C. J. (2018). Identity override: How sexual orientation reduces the rigidity of racial boundaries. *Sociological Science, 5*(28), 669–693. http://dx.doi.org/10.15195/v5.a28

Hudak, J., & Giammattei, S. V. (2014). Doing family: Decentering heteronormativity in "marriage" and "family" therapy. In T. Nelson & H. Winawer (Eds.), *Critical topics in family therapy* (pp. 105–115). Springer. https://doi.org/10.1007/978-3-319-03248-1_12

Johnson, S. (2012). Gay affirmative psychotherapy with lesbian, gay and bisexual individuals: Implications for contemporary psychotherapy research. *American Journal of Orthopsychiatry, 82*(4), 516–522. https://doi.org/10.1111/j.1939-0025.2012.01180.x

Knudson-Martin, C., & Laughlin, M. J. (2005). Gender and sexual orientation in family therapy: Toward a post-gender approach. *Family Relations, 54*(1), 101–115. https://doi.org/10.1111/j.0197-6664.2005.00009.x

Knudson-Martin, C., & Mahoney, A. R. (2009). *Couples, gender, and power: Creating change in intimate relationships*. Springer. https://doi.org/10.1891/9780826117564

LaSala, M. C. (2013). Out of the darkness: Three waves of family research and the emergence of family therapy for lesbian and gay people. *Clinical Social Work Journal, 41*(3), 267–276. https://doi-org.pnw.idm.oclc.org/10.1007/s10615-012-0434-x

Laszloffy, T. A., & Hardy, K. V. (2000). Uncommon strategies for a common problem: Addressing racism in clinical practice. *Family Process, 39*(1), 35–50. https://doi.org/10.1111/j.1545-5300.2000.39106.x

Lefevor, G. T., Janis, R. A., Franklin, A., & Stone, W. -M. (2019). Distress and therapeutic outcomes among transgender and gender nonconforming people of color. *The Counseling Psychologist, 47*(1), 34–58. https://doi-org.pnw.idm.oclc.org/10.1177/0011000019827210

Leland, W., & Stockwell, A. (2019). A self-assessment tool for cultivating affirming practices with transgender and gender-nonconforming (TGNC) clients, supervisees, students, and colleagues. *Behavior Analysis in Practice, 12*(4), 816–825. https://doi-org.pnw.idm.oclc.org/10.1007/s40617-019-00375-0

Lev, A. I. (2013). Gender dysphoria: Two steps forward, one step back. *Clinical Social Work Journal, 41*(2), 288–296. https://doi.org/10.1007/s10615-013-0447-0

Lev, A. I. (2019). Approaches to the treatment of gender diverse children and transgender youth. In A. I. Lev & A. R. Gottlieb (Eds.), *Families in transition: Parenting gender diverse children, adolescents, and young adults* (pp. 160–187). Harrington Park Press.

Levitt, H. M., & Ippolito, M. R. (2014). Being transgender: Navigating minority stressors and developing authentic self-presentation. *Psychology of Women Quarterly, 38*(1), 46–64. https://doi.org/10.1177/0361684313501644

Long, J. K., & Serovich, J. M. (2003). Incorporating sexual orientation into MFT training programs: Infusion and inclusion. *Journal of Marital and Family Therapy, 29*(1), 59–67. https://doi-org.pnw.idm.oclc.org/10.1111/j.1752-0606.2003.tb00383.x

Machado, C. M. (2019). *In the dream house.* Graywolf Press.

Malpas, J. (2011). Between pink and blue: A multi-dimensional family approach to gender nonconforming children and their families. *Family Process, 50*(4), 453–470. https://doi-org.pnw.idm.oclc.org/10.1111/j.1545-5300.2011.01371.x

Martín-Baró, I. (1994). *Writings for a liberation psychology*. Harvard University Press.

McGeorge, C. R., & Carlson, T. S. (2016). The state of lesbian, gay, and bisexual affirmative training: A survey of faculty from accredited couple and family therapy programs. *Journal of Marital and Family Therapy, 42*(1), 153–167. https://doi.org/10.1111/jmft.12106

Nealy, E. C. (2017). *Transgender children and youth: Cultivating pride and joy with families in transition.* Norton.

Pharr, S. (1997). *Homophobia: A weapon of sexism.* Women's Project.

Porter, K. E., Brennan-Ing, M., Chang, S. C., dickey, lore m., Singh, A. A., Bower, K. L., & Witten, T. M. (2016). Providing competent and affirming services for transgender and gender nonconforming older adults. *Clinical Gerontologist: The Journal of Aging and Mental Health, 39*(5), 366–388. https://doi-org.pnw.idm.oclc.org/10.1080/07317115.2016.1203383

Real, T. (2002). *How can I get through to you? Closing the intimacy gap between men and women.* Simon & Schuster.

Real, T. (2007). *The new rules of marriage: What you need to know.* Ballantine Books.

Rich, A. (1986). *Of woman born: Motherhood as experience and institution.* Norton.

Ritter, K. Y., & Terndrup, A. I. (2002). *Handbook of affirmative psychotherapy with lesbians and gay men.* Guilford Press.

Rock, M., Carlson, T. S., & McGeorge, C. R. (2010). Does affirmative training matter? Assessing CFT students' beliefs about sexual orientation and their level of affirmative training. *Journal of Marital and Family Therapy, 36*(2), 171–184. https://doi.org/10.1111/j.1752-0606.2009.00172.x

Singh, A., & dickey, l. m. (Ed.). (2017). *Affirmative counseling and psychological practice with transgender and gender nonconforming clients.* American Psychological Association. https://doi-org.pnw.idm.oclc.org/10.1037/14957-000

Singh, A. A. (2016). Moving from affirmation to liberation in psychological practice with transgender and gender nonconforming clients. *American Psychologist, 71*(8), 755–762. https://doi.org/10.1037/amp0000106

Stone Fish, L., & Harvey, R. G. (2005). *Nurturing queer youth: Family therapy transformed*. Norton.

Sue, D. W. (2010). *Microaggressions in everyday life: Race, gender, and sexual orientation*. Wiley.

Tasca, C., Rapetti, M., Carta, M. G., & Fadda, B. (2012). Women and hysteria in the history of mental health. *Clinical Practice and Epidemiology in Mental Health, 8*, 110–119. https://doi.org/10.2174/1745017901208010110

Walsh, F., & Scheinkman, M. (1989). (Fe)male: The hidden gender dimension in models of family therapy. In M. McGoldrick, C. M. Anderson, & F. Walsh (Eds.), *Women in families: A framework for family therapy* (pp. 16–41). Norton.

Walters, M., Carter, B., Papp, P., & Silverstein, O. (1988). *The invisible web: Gender patterns in family relationships*. Guilford.

Zoeterman, S. E., & Wright, A. J. (2014). The role of openness to experience and sexual identity formation in LGB individuals: Implications for mental health. *Journal of Homosexuality, 61*(2), 334–353. https://doi-org.pnw.idm.oclc.org/10.1080/00918369.2013.839919

2
Intercultural Issues in LGBTQ+ Couple and Family Therapy

Supporting Empowerment and Resilience at the Intersection of Identities

AMNEY J. HARPER and ANNELIESE A. SINGH

Introduction

More often than not in the scholarship on lesbian, gay, bisexual, trans, queer, questioning (LGBTQ+) couples and families, there are silences with regard to the inclusion of the needs and concerns of LGBTQ+ people who hold additional historically marginalized identities. Instead, LGBTQ+ practice and research typically neglect to explore issues of race and ethnicity, gender identity and expression, ability status, social class, immigration status, and other salient identities LGBTQ+ couples and families may hold. In doing so, the overall focus of this area in psychotherapy with LGBTQ+ couples and families becomes synonymous with dominant groups in society, namely, white, middle-class, gay men—and a Western perspective on couples and psychotherapy. Heeding the call of Kimberle Crenshaw regarding intersectionality theory (1991), it is crucial that therapists understand the wide range of experiences LGBTQ couples and families have as well as how interlocking oppressions (e.g. racism, sexism, classism, ableism) uniquely affect their lived experiences of multiplicative privileges and oppressions. This takes on special importance, given current population trends, which project that the U.S. will become "minority white" by 2045 (Frey, 2018) and that racial/ethnic diversity is no longer being driven by immigration, but instead by birth rates in the U.S., as suggested by the Population Reference Bureau (Mather et al., 2019).

Therefore, we must note that

> children are at the forefront of racial/ethnic change in the United States, creating a diversity gap among generations. Only half of the population under age 18 are projected to be non-Hispanic white by 2020, compared with three-fourths (76 percent) of those ages 65 and older.
>
> *(Mather et al., 2019, pp. 11–12)*

However, it is also important to note that while white people will be in the minority, wealth and power will still be concentrated in white communities due to generations of racist policies and practices within the U.S. (e.g. gerrymandering, voter ID laws, housing loan discrimination; Poston & Saenez, 2017).

As LGBTQ+ identities intersect with various cultural identities, what results are interlocking systems of power and oppression (Crenshaw, 1991) that LGBTQ+ people must navigate and which uniquely impact the individual's experience within the context of their relationships. Therefore, a major component of ethical and competent practice in this regard is ensuring an intercultural approach to counseling. An *intercultural* approach refers to therapist intentions to validate and affirm the wide range of cultures from which LGBTQ+ couples and families come

DOI: 10.4324/9780429274626-4

from, and the recognition that therapists bring their own biases, attitudes, and worldviews into the therapeutic relationship. The purpose of this chapter is to describe key components of an affirmative, intercultural approach to therapy with LGBTQ+ people which supports their resilience and empowerment in the face of interlocking oppressions. These key components include (a) specific ways that multiple and interlocking oppressions LGBTQ+ couples and families experience can create barriers and unique developmental and relational challenges; (b) the impact of oppression on intimacy within couples, families, and also within the relationship between client and therapist; (c) expecting and assessing for the resilience of LGBTQ+ people as they navigate multiple streams of oppression; and (d) the capacity of therapists to be multiculturally competent and effective at mitigating the deleterious effects of oppression on mental health. In this chapter, we describe each of these components. In doing so, this chapter also troubles the traditional definitions of *couple* and *family* that are used to frame LGBTQ people as well as clinical practice with LGBTQ+ people.

Case Study 1: Addition to the Family?

Jazmín and Isidora have been married for six years. They married a year and a half after they began dating. Jazmín (she/her/hers) is a 26-year-old trans woman whose family immigrated to the U.S. when she was two years old from Ecuador. Her parents recently shared that the family did not have documentation when Jazmín was in high school. Her family initially had been following formal regulations to be able to stay in the U.S.; however, her father was arrested and thus lost his eligibility for U.S. citizenship. Jazmín's family had built a life and community in the U.S., so they decided to stay in the U.S., recognizing the many challenges they would face without documentation papers. Currently, Jazmín has minimal contact with her family because after she shared her gender identity, they insisted on deadnaming[1] her, refused to use pronouns, and neglected to attend her wedding because they do not believe that her gender identity is in alignment with their Roman Catholic religious beliefs.

Isidora (they/them/theirs) is a 28-year-old first-generation Guatemalan American. Isidora identifies as nonbinary. Isidora lives with fibromyalgia and has survived domestic violence and multiple sexual assaults. Isidora has shared with their family and work colleagues that they are queer. Isidora shared their nonbinary identity with friends last year. They are not out as nonbinary to their family or at work. Their family is marginally supportive, and are also Roman Catholic. Isidora has a tense, but mostly positive relationship, with their family. There is a lot of silence around their identity, largely based on things their family doesn't understand about their gender identity. From many things they have said and done, Isidora is certain that their family will not understand and they do not feel comfortable coming out at this time.

When they met, Jazmín had just begun her social and medical transition. At the time of their marriage, they describe being madly in love and having nearly everything in common. Much of the energy of the relationship initially was focused on Jazmín's transition, and then recently on Isidora's coming out as nonbinary. They have been quite inseparable over the past six years, and have provided excellent support to one another. However, recently Jazmín started talking to Isidora about having children. Isidora never imagined their life with children and assumed Jazmín felt the same. At the time they were married, the couple made a mutual decision to not have children, but recently Jazmín has changed her mind. Isidora is very concerned about how managing fibromyalgia and trauma would be complicated by parenthood. Additionally, due to the difficulty within their families, Isidora doesn't want to bring a child into the current political climate. While Isidora values family highly, they are cautious about having children because

[1] Deadnaming refers to using the name given to a transgender person at birth instead of their current name.

they are concerned specifically that their child would experience and learn transprejudice and homoprejudice from family members.

Additionally, they both share concerns about Jazmín's legal status in the U.S. and what that might mean for their family if they decide to have children. Discussions about having children have become frequent and intense and for the first time in their relationship they are feeling distant from one another. This has affected their physical intimacy as the arguments become more frequent and damaging. Jazmín fears that if things continue as they are, their differences might become irreconcilable. They come to therapy to help sort out the next steps in their relationship.

Jazmín and Isidora come into the therapy process with many strengths. Up until this point, they have had a strong relationship marked by deep connection and caring. In particular, each partner describes the other as providing excellent support related to their identity development. The therapist ought to begin with the couple's strengths, particularly identifying specific strategies they have used in the past to navigate conflict. This can serve as a foundation to provide strategies that may be useful in helping them navigate what is happening between them now.

The growing conflict in the relationship between Jazmín and Isidora is complicated by the socio-political context in which they live. Not only do they face conflict in their families of origin due to homoprejudice and transprejudice, which are based at least in part in religion, they are also facing barriers and stressors related to Jazmín's status in the U.S. In the current climate within the U.S., experiences of violence toward LGBTQ+ people (particularly trans people) as well as toward people of color (and specifically immigrants) have been growing. Additionally, threats of family separation for those who are at risk of deportation due to current immigration policies require serious consideration. The couple did not mention these socio-cultural stressors to the therapist; yet, it would be important for an affirmative therapist to inquire about how/if they may have experienced homoprejudice, transprejudice, racism, anti-immigrant discrimination, or ableism in the world as well as how they may have internalized these experiences.

To work affirmatively with Jazmín and Isidora, a therapist will need to not only understand the oppressive conditions within the current U.S. socio-political context and its influence on their relationship, but also to have access to community resources and strategies to support their resilience and empower them to resist. In addition to navigating their personal desires related to having children and the conflict this creates, their differing legal status means that they have unequal legal rights and options available to them as potential parents. These differences in their individual social status add a layer of stress and must be considered as they attempt to make a decision as a couple. However, leaning into how they have each been resilient throughout their lives will help to build on how they may tackle these current concerns as well. Additionally, it would be important to ensure that they both know their rights related to parental rights, immigration, and deportation.

In addition to the socio-political context, it would also be important to address Isidora's underlying trauma as well as their fibromyalgia diagnosis. This might entail addressing trauma in individual therapy (if this isn't already happening), and/or the therapist or Isidora may need to consult with their physician related to what they might expect related to their health if they were to consider having children with Jazmín. Another important concern to address would be related to how they are talking about growing a family and what the implications of this might be. For example, if they choose to have Isidora carry a child, it would be important to explore the impact any experiences they may have within their body, such as body dysphoria or to see what their options might be related to fostering/adopting, given Jazmín's immigration status. There are many considerations related to the possibility of parenthood, and finding out what it would mean for them financially, physically, and emotionally may uncover additional areas to navigate

within the current issue. It also would be important for the couple to explore what it will mean for their relationship if they remain divided on the question of having children.

The Impact of Oppression on LGBTQ+ Intimacy

Before we review the major practice issues that emerge with diverse LGBTQ+ families and couples, we first must interrogate the words *couple* and *family*. In traditional psychotherapy, of course, a couple is assumed to be a straight couple in which there is one person who has been assigned male at birth and one person who has been assigned female at birth, with both assignments based on anatomy. Just as traditional couple therapy that focuses on straight concerns neglects LGBTQ+ issues, when LGBTQ+ couple therapy does not take into account diverse LGBTQ+ couples, inevitably there are concerns that go unaddressed. Similarly, traditional family therapy has focused on family child-rearing; however, LGBTQ+ families are often families of choice, formed through active efforts to build community as a result of oppression.

Yet, when diverse LGBTQ+ families come to therapy, it is important to understand that because of their varied life experiences, definitions of family are more complicated, expansive, and often defy traditional conception. When a same-sex couple decides to have children, a series of relationship systems have to be worked out which may include biological relationships and family of choice. LGBTQ families come in many forms and they begin in a variety of ways that may or may not include biological, extended family, and adoptive ties. Some LGBTQ+ families have two parents where at least one parent has biological ties to the child/children using a donor and intrauterine or invitro fertilization. Other two-parent families adopt children; still other same-sex partners may develop a relationship (romantic or platonic) with another biological parent, who may or may not also live in the home or have regular contact with the child or children. Some LGBTQ+ families are single-parent households either by choice or following the dissolution of a relationship. Another possible makeup of families is two sets of same-sex couples who all take equal responsibility for parenting and may or may not be biologically related to the child or children. Still, other families have biological children from a previous heterosexual or LGBTQ relationship, which would mean that the child or children have, for example, three mothers, one father, or some other combination.

Transgender parents may have biological children either before their transitions or after (as when a trans man decides to carry a child), or they too may adopt or enter a relationship with a partner who already has children. In families where one parent is transgender or nonbinary, a child or children may refer to the parent with a nontraditional term (e.g. a combination of the words *mother* and *father* to make *maddy*, or using a shortened version of *parent*, such as *ren* or *renny*) based on when the parent came out or transitioned in relation to when they became a parent.

The general literature on couple and family therapy practice has attended to issues of blended families. However, LGBTQ+ couples can experience these issues very differently. Interpersonal and group dynamics are also influenced by individual cultural values and worldviews within the relationship, and there can be markedly different worldviews that shape communication styles and what it means to build a relationship and/or family. For instance, there may be similar or dissimilar views on issues such as finances, dissolution of relationship, and degree of family connection. Also, acceptance or rejection of transgender identity by previous partners and children can antagonize and/or complicate navigating issues such as custody and parenting. Similarly, a partner who transitions in the context of an unsupportive blended family faces additional barriers which impact the entire system, including the new couple relationship.

We can further trouble the concept of couples through thinking about it linguistically. *Couple* indicates two romantic partners. However, in polyamorous relationships, romantic relationships may involve three or more partners. These relationships take on a variety of configurations. For example, relationships may be made up of a primary couple with a secondary relationship, which may or may not include both partners of the primary relationship. However, this relationship may also include all three (or more) partners equally engaging in the relationship. Here, it is important to remember that queer identities, particularly polyamorous relationships, trouble the heteronormative. These are just a few examples of how they do so. It is important when working with any LGBTQ+ couples that the therapist consider the limitless possibilities of how families and such couples may be constructed and then undermined by traditional notions of "family." Additionally, these nontraditional constructions of families may be subjected to added layers of oppression, including being misunderstood, disrespected, and scorned by families which surround them. In this chapter, we use the term *couples* and *partners* interchangeably.

Although the literature to date has not made direct links to the impact of oppression on intimacy and desire, it is worth considering how experiences of oppression may impact partners' experiences within their relationship. Some literature exists that begins to address these issues, such as the role of coming out in relationship satisfaction (Jordan & Duluty, 2000) and experiences of homoprejudice and increased arguing and sexual problems (Green & Mitchell, 2002), which makes it easy to understand how partners with differing levels of outness may face particular struggles that their straight counterparts do not. It is important to note that LGBTQ+ individuals have varied experiences of the "closet," and clients' narratives about their experience vary widely. Some find the secrecy of being in the closet seductive and arousing, whereas others find only worry in the possibility of being found out, including the danger of violations of their personal safety. We know from the minority stress model (Meyer, 2015) that the daily stressors that come from oppression add to the overall stress of individuals with marginalized identities. Considering the role that stress may have on intimacy, these issues may be particularly salient for LGBTQ+ partners with additional marginalized identities. In the case of Jazmín and Isidora, we see that the stressors related to the question of adding children to their relationship have strained their connection. We might wonder, for example, how Isidora's fears and worries about adding children to their family are related to the additional oppressions they routinely face. Similarly, how do each of their day to day experiences of oppression grind down their ability to be vulnerable with one another, or their sense of desire for each other?

Regardless of the specific concerns that diverse LGBTQ+ partners and families bring into therapy, Singh and Chun (2010) encourage practitioners to use a resilience perspective when multiple salient identities and intercultural dynamics are present in the therapy room. *Resilience* is the ability an individual and/or a community has to cope positively with life's stressors (Werner-Wilson et al., 2000). Despite the experiences of oppression that diverse LGBTQ+ families and couples have and the potential for internalizing oppression, these groups also develop coping strategies that often assist them in navigating experiences of prejudice and discrimination. Affirmative therapists must be proficient at knowing and being able to discuss typical oppressive experiences that diverse LGBTQ+ families and couples navigate while simultaneously being able to explore the resilient coping strategies these families and couples develop.

LGBTQ+ Resilience

Although the majority of research on LGBTQ+ resilience has not focused on couples and family, there are some key aspects of this research that can inform intercultural therapy approaches with LGBTQ+ families and partners. First, resilience has been defined as the ability to bounce back from adversity. However, this construct is not only an individual experience, but resilience can

be fostered and nurtured by community connection, support, resources, and advocacy (Singh et al., 2011). For instance, LGBTQ+ couple and families moving through major milestones in life (e.g. family building, raising an adolescent, managing relationships with families of origin) can increase their resilience when they have access and support from community resources and advocates who provide ways to navigate potential LGBTQ+ oppression they may face.

Second, community support can counter the isolation that LGBTQ+ couples and families may experience in a society that prioritizes straight and cisgender couples and families as the norm and actively ignores or denigrates other family forms. This community support can increase resilience through increasing connection, but also through providing models and norms to "look to" when navigating life as an LGBTQ+ couple and family. Finally, LGBTQ+ resilience can be increased for couples and families when they know how to advocate for themselves as they navigate anti-LGBTQ+ bias. This knowledge and confidence of self-advocacy, as well as the knowledge of how to reach for LGBTQ+ advocates who are affirming, helps lower the burden of minority stress and increase their capacity to not just survive in life, but thrive. Therapists play a key role in supporting LGBTQ+ resilience—each time we name the impact of LGBTQ+ oppression in the lives of LGBTQ+ partners and families, we support clients in not internalizing anti-LGBTQ+ oppression.

Building Multicultural and Social Justice Competence

An initial step in understanding diverse intercultural issues LGBTQ+ couples and families face is to have a strong understanding of multicultural and social justice counseling competencies. Perhaps the most well-known multicultural competencies outline three domains in which therapists should develop: awareness, knowledge, and skills (Sue et al., 1992). However, therapists should be aware that these 1992 competencies were revised in 2015 (Ratts et al., 2016) as the *Multicultural and Social Justice Counseling Competencies*, and now include an additional developmental domain of "action," which embeds advocacy within counseling. In addition, the revised competencies describe the different intersections of privilege and oppression identities therapists and their clients may have.

Therapist attitudes and beliefs (often referred to as therapist self-awareness) refers to the beliefs and attitudes practitioners have about the various cultural groups in society. For instance, affirmative therapists must assess their own biases and assumptions about LGBTQ+ couples and families partly by exploring their beliefs and attitudes about this group as a whole but perhaps most importantly by exploring their own salient cultural identities and assessing the differences and similarities that exist. In order to fully explore one's beliefs and values, it is also important to understand one's personal experiences with privilege and oppression. Removing the veil of invisibility that usually accompanies privilege requires ongoing self-reflection as well as becoming aware of the systemic nature of oppression and privilege that shape one's experience in the world. This practitioner self-awareness is a crucial step in multicultural competence because these beliefs and attitudes often drive the value systems that practitioners bring into the psychotherapy experience.

For example, a straight, cisgender, white therapist may want to be inclusive in their work with LGBTQ+ couples and families of color; however, they may lack an understanding of the specific lived experiences of these groups, therefore unintentionally perpetuating oppression within the therapy relationship. Similarly, white LGBTQ+ therapists may assume they know all about the LGBTQ+ community because they are a part of an LGBTQ+ community, and may miss the important ways that that clients of color experience their identities and relationships within their families and communities. A common example of this would be a white LGBTQ+ therapist overvaluing separating from families who are intolerant of LGBTQ+ people assuming from a

place of whiteness that such a separation would best support the client's mental health. On the contrary, many clients of color would value staying connected to family and being more accepting of intolerant family members because these family systems have supported them as they navigate racism in ways the white LGBTQ+ community could not. Moreover, they understand their family members in the context and wider systems of race and oppression. For example, a client's view of what their parents gave up to immigrate to the U.S. may outweigh the parent's intolerance toward their sexual or gender identity. These clients need help navigating nuanced ways of staying connected to families and communities of origin that are unique and culturally sensitive.

In the case study, a therapist might assume that because Isidora has a positive relationship with their family, that they would eventually want to come out as nonbinary to them and that it would be worth the risk to do so. Or a therapist might assume the opposite—that because Isidora and Jazmín are not that close with their families of origin and because of the biases their families hold, they may not value their family relationships in spite of the limitations. A therapist could assume that they are empowering Jazmín and Isidora by joining with their hurt and urging them to protect themselves from disrespectful treatment by their families, when Jazmín and Isidora may not experience it like that at all. This becomes a barrier to therapy as the energy may then turn to the need the couple feels to now defend their families to their therapist.

The second domain of multicultural and social justice counseling competence, *knowledge*, is the ability to seek out information about specific cultural groups. Enhancing knowledge about LGBTQ+ couples and families might, for example, as in our case study, involve seeking information about the specific traditions, practices, and worldviews of Ecuadorian and Guatemalan families and couples in order to understand how these factors may influence coping and resilience to stressors. Knowing only generalities about Latinx culture may be helpful, yet is not specific enough for the therapist working with Jazmín and Isidora. The knowledge domain entails an active and ongoing process of gathering information. So, if one is working with an LGBTQ+ couple whose cultural identities are very different from those of the practitioner, the therapist will want to consume the most current research and practice literature about the clients' cultural group in addition to LGBTQ+ identities. The ongoing process refers to the practitioners seeking to be exposed to diverse cultural experiences in order to expand their knowledge of diverse individuals and communities.

The third domain, *skills*, aims to ensure that culturally relevant strategies are used within counseling practice that are appropriate and match the needs and concerns of clients. For instance, a therapist working with LGBTQ+ couples and families who are negotiating immigrant experiences in the U.S. would need to not only have the awareness and knowledge of common concerns of this group, but also the skill set to specifically address these concerns. This should include specific interventions used but also encompass a theoretical framework that works well with the worldview of the couple or family.

The fourth domain, *action*, refers to the important ways that therapists can use their privilege as a mental healthcare provider to challenge oppressions that influence their clients and support them in accessing necessary resources that help them navigate oppression. This developmental domain encourages therapists to understand how historical events and current socio-political issues shape the mental health of their clients, as well as empowerment approaches that help them thrive despite these societal inequities. These actions can include a range of activities from professional development to learning social justice theories and immersing one's self in specific ethnic communities to further understand how privilege and oppression influence their approach to counseling, including variety of ways that cultures communicate. As therapists

develop an active, ongoing commitment to developing multicultural and social justice competency, there are advocacy competencies for counseling that may help guide them (Toporek & Daniels, 2018).

Because intercultural issues not only are based in one's own identity or the identity of one's cultural groups but also relate to specific issues of how the world responds to these identities, therapists working with diverse LGBTQ+ couples and families should also understand the various social justice concerns that may be related to having diverse identities. Once well informed, affirmative therapists can seek both to empower clients' marginalized identities to advocate for themselves and to advocate on their behalf (Ratts et al., 2016). In order to understand issues of social justice, similar to the initial step in multicultural competence, practitioners should be aware of their own identities, but as these identities specifically relate to issues of privilege and oppression. *Privilege* has been described as the "unearned advantages" that dominant groups in societies may have (e.g. being white, male, straight, or able-bodied or having middle- or upper-class social status; McIntosh, 1989, p. 52). *Oppression* is defined as the experience of prejudice and discrimination as a result of being a member of a group that has historically been marginalized (e.g. women, people of color, immigrants, or LGBTQ+ individuals).

It is also important to understand how privilege and oppression operate together as two sides of the same coin (D'Amico, 2003). For example, while some persons have the privilege of not having their race/ethnicity work against them in finding housing, other persons are denied the same access to housing because of oppression based on their race/ethnicity. Awareness and understanding of privileges as well as the corresponding oppression help practitioners focus on social justice issues (e.g. racism, sexism, heterosexism, ableism, or classism) that they might neglect to address based on their own invisible experiences of privilege (Singh & Salazar, 2010). For example, in our earlier example, the white LGBTQ+ therapist could focus on their similarity with Jazmín and Isidora (being members of the LGBTQ+ community) and miss or undervalue what the differences mean (e.g. not having to experience racism and homoprejudice or transprejudice together). In this example, a therapist who is cisgender, but

Table 2.1 Identities and Related Privileged and Oppressed Statuses

Identity	Privileged Status	Oppressed Status
Ability status	Able-bodied	Physical or mental health disability
Gender	Men	Women, trans/nonbinary
Sex	Male	Intersex, female
Gender identity and expression	Cisgender	Trans/nonbinary
Immigration status	U.S. citizen (white)	Immigrant (people of color)
Race and ethnicity	White, non-Hispanic	People of color
Sexual orientation	Straight	LGBQQ, polyamorous, asexual
Social class	Middle to upper class	Poverty, working class
Religion and spirituality	Judeo-Christian	Muslim, Eastern, Pagan, Indigenous, Atheism, etc.
Education level	Access to higher education	High school, GED, noncompletion
Language	English as first language	English as second language, not English speaking
Political views	Republican, Democrat	Radical, progressive
Nationality	U.S. citizen (White), Western European	Eastern European, Asian, African, Latinx, Middle Eastern, Canadian

lesbian, gay, or bisexual, may similarly assume that they are equally oppressed or that their experiences with homo- or biprejudice may be the same kind of experience as the transprejudice that Jazmín and Isidora may experience. Systems of privilege and oppression exist within institutions and also affect the access, equity, and participation of diverse LGBTQ+ couples and families, who may or may not have access to various resources they need (Singh, 2010). See Table 2.1 for a listing of multicultural identities with their related privilege or oppression status.

Multiple and Interlocking LGBTQ+ Oppressions and Identities

As noted in Table 2.1, there are many layers of interlocking oppressions that assign unique combinations of privileges and/or oppressions which LGBTQ+ people experience related to their identities. When a person holds more than one marginalized identity, there are many considerations to be taken into account. There has been much written about identity development of lesbian, gay, and bisexual people, as well as people of color and other marginalized identities (Atkinson et al., 1989; Bleiberg et al., 2005; Brown, 2002; Cross, 1991; Helms, 1995; Klein, 1993). There is also literature on biracial and multiracial identity development (Harper & Swanson, 2019; Poston, 1990; Root, 2003). When considering the identity development of someone who simultaneously holds two marginalized identities (e.g. race and sexual orientation), however, some additional considerations need to be made.

In 2005, Poynter and Washington described the complex process of multiple identity development. They describe this process as nonlinear and having two distinct trajectories: individual and group. For instance, an Asian American/Pacific Islander (AAPI) nonbinary person has the individual development of their race/ethnicity and their gender identities, while they also experience multiple identity development related to their experiences within and between these two groups.

The authors then identify the potential outcomes of multiple identity development. The most optimal of which is when individuals are able to integrate multiple identities into their self-concept and comfortably hold multiple group identities or memberships. With an AAPI nonbinary client, the optimal outcome is for them to feel secure in their multiple identities in both nonbinary and AAPI communities. Two other outcomes that are not as beneficial to well-being and sense of self are to identify with only one group while ignoring other aspects of one's identity, or to identify with only one group at a time. In this case, an AAPI nonbinary person may not experience affirmation of all of their identities in either their AAPI or nonbinary community, but feel that one of their communities is more affirming than the other. In the next sections, we address how other specific identities intersect with LGBTQ+ identities. It is important to realize, however, that each layer of identity, visible or otherwise, presents unique challenges that should be considered when working with individuals, couples, or families with multiple identities. We will briefly cover some of these variables according to the identities presented in Table 2.1.

Ability Status in LGBTQ+ Couples and Families

Ability status refers to presence or absence of physical, emotional, and mental disability. For instance, a person who is able-bodied has fewer barriers in the world related to their physical and mental health than has a person with a disability because the world is built for people who are able-bodied; for example, a person living with a disability may have societal obstacles to navigate in their daily life (e.g. the lack of accessible buildings for people using wheelchairs, the absence of quality and accessible mental healthcare for people with mental health diagnoses) as they attempt to live a full life. In the case study at the start of the chapter, Isidora has a diagnosis of fibromyalgia and has a history of trauma. Isidora likely encounters bias from others when

they have a pain flare and/or requires accommodations or needs time off work, for example. Ableism is the system of oppression that privileges able-bodied people.

Assigned Sex in LGBTQ+ Couples and Families

Assigned sex refers to the label of male, female, or intersex that is assigned to people at birth based on perceived anatomy and chromosomes. *Gender* refers to the identity and expression of one's sense of gender and is often based on the sex assigned at birth. *Sexism* is the system of oppression that privileges men over women and boys over girls.

Religion and Spirituality in LGBTQ+ Couples and Families

The identity of *religion* and *spirituality* has historically received less attention from practitioners with regard to LGBTQ+ couples and families, and they are often assumed to be non-religious; however, it is an identity that is often closely related to value systems and coping resources, so it can be very important. With regard to this status, Judeo-Christian religions are those that hold privileged statuses, whereas other faith traditions and those individuals who identify as agnostic, atheist, or nonbelievers are target groups. For LGBTQ+ people, most major religious traditions have a history (and many have a current practice) of being openly hostile, or—at a minimum—unaccepting or invalidating of LGBTQ+ people. The practice of conversion therapy most often has been rooted in religious practice, for example, and is widely understood by the mental health community as harmful to LGBTQ+ people. Also, many families and communities take their cues from these religious traditions when rejecting LGBTQ+ members. Similarly, anti-LGBTQ+ political stances in the U.S. most often cite Christian reasoning. These political forces have resulted in legal discrimination and limited freedoms and rights for LGBTQ+ people in the U.S.

Race and Ethnicity in LGBTQ+ Couples and Families

Race and ethnicity is a composite related to how race and ethnicity have been defined and categorized. The U.S. system of *racism* privileges white people over the group targeted by this oppression, people of color. *Immigration status* refers to the access one has in the U.S. to legal documents "legalizing" one's residence in this country. *Language* is often related to race, ethnicity, and immigration status in the U.S., where the privileged groups are those who have facility with English. *Nationalism* is the system of oppression that privileges those holding citizenship.

For LGBTQ+ people of color and LGBTQ+ immigrants, racism and ethnocentrism can add an additional layer into one's experiences of homo/bi/transprejudice. For example, transgender women of color experience the highest rates of violence in all of the LGBTQ+ communities, demonstrating the added weight that these intersecting identities encounter. Also, currently LGBTQ+ individuals seeking asylum in the U.S. are experiencing additional challenges because of the current political climate that is both anti-immigrant and anti-LGBTQ+, and these folks are exceptionally vulnerable as they are often seeking asylum related to dangers they experience in their countries of origin because they are LGBQT+.

Black LGBTQ+ Couples and Families About 13.4% of the general U.S. population is Black, African American, or has African heritage (U.S. Census Bureau, 2018), currently making this group one of the largest ethnic minority communities in this country. A much-neglected subgroup within this community are immigrants from African countries, who may have distinctly different experiences and worldviews than their African American counterparts. Much of the recent literature in family therapy with individuals of African descent has focused on the importance of exploring the context of family connections, extended kinship networks, and issues of religion and spirituality affecting the lives of family members (Locke & Bailey, 2014).

For this reason, it is important to carefully assess how each of these dimensions is experienced by individuals and the related meaning they attach to them in regard to the presenting issue. For instance, in counseling an LGBTQ+ African American family presenting with concerns about a teenaged daughter's relationship with her peers, exploring how extended kinship and family networks influence this issue may be important.

Gender is an important factor within any racial or ethnic group in the U.S., and this is certainly true with regard to partners' and families' concerns in therapy. Avoiding assumptions and stereotypes about gender roles is a good rule to follow; thus, practitioners might instead explore how clients' gender and race or ethnicity intersect for them. African American women may come in with concerns about shifting roles among the variety of contexts they inhabit—from work and professional relationships to family and other personal social networks (Anglin, 2006; Bowleg et al., 2003). For instance, an African American lesbian may have to shift her personality and approach to life to fit into a white norm at work, whereas in her home community she may have to shift "back" to an entirely different mode of relating to others. Another example might be working with an African American gay transgender man whose family may understand his gender identity but may not want him to tell others that he is in a relationship with another man.

A common theme in the literature with LGBTQ+ African Americans is the idea of *Don't Ask, Don't Tell* (Miller & Parker, 2009). This phrase is used to describe the family dynamic wherein LGBTQ+ members may feel accepted by their families, but their families ask them not share this information with others. In a study of coming out disclosures of African American daughters to their mothers, Miller and Parker (2009) found that mothers were typically supportive of their daughters' sexual orientation, yet they asked their daughters not to disclose their orientations to others in their extended family. Church holds a particular space in the lives of African Americans because of the historical use of Black churches for political organizing during the Black freedom struggle. Even families who have a strong understanding of oppression as it relates to race (and who may not themselves be particularly active or connected to Christianity) may struggle with accepting LGBTQ+ identities, which go against traditional Christian religious values (Schlosser, 2003).

Latinx LGBTQ+ Couples and Families According to the 2018 U.S. Census, the Latinx[2] population living in the U.S. is at 18.3%, making them the largest ethnic and racial minority group in the U.S. (U.S. Census Bureau, 2018). Given that there are many people living in the U.S. without citizenship status, this number may be higher than estimated by the U.S. Census Bureau. There are many intergroup differences among Latinx peoples, who hail from many different countries and cultural groups with varied cultural practices and traditions. Important considerations related to intergroup differences when working with Latinx LGBTQ+ couples and families are language, citizenship status, country of origin and level of acculturation, class, and religion and spirituality.

In working with Latinx LGBTQ+ couples and families, it is important to consider the role of varied Latinx cultural beliefs, values, and practices. Probably the most relevant and common cultural value is the central role of the family. Because of the importance placed on family in Latinx cultures, it is not surprising that Latinx families make up the largest group of same-sex partners who raise children and utilize adoption (Family Equity, 2008). The 2010 Census showed that 41.5% of female same-sex partners are raising children and 22.6% of male Latinx partners

[2] Note that the U.S. Census Bureau uses the term *Hispanic*. This term, however, is not currently the designation preferred by the Latinx peoples whom it purports to identify. Thus, the term will not be used in this chapter. Also note that when working with LGBTQ+ Latinx couples and families or any group, practitioners must be mindful to use the term preferred by each individual.

are raising children (Gates, 2012). Given this information, it may be particularly important when working with LGBTQ+ couples to explore, when appropriate, the role of family and concerns related to children. When considering typical cultural practices within Latinx cultures, the therapist needs to consider how individuals might differ. In our case, Isidora expresses not wanting children. They might experience pressure to do so within their family, but also could experience this from their partner or therapist if the therapist assumes that having children will be important to them.

Another very important consideration in working with Latinx LGBTQ+ couples and families is the notion of traditional gender roles. After the colonization of Mexico and Latin America, the predominant religion became Christianity, particularly Catholicism (Klar, 1993). This religion played a large role in the formation of rigid gender roles, which impact the lives of Latinx LGBTQ+ people and contribute to their oppression in very specific ways. Within this rigid construction of gender roles, being straight and cisgender are considered the norm, and everything else is considered abnormal. Despite this rigid division, many Latin American countries have recently legalized gay marriages and/or civil unions (Lodola & Corral, 2010). Although support for LGBTQ+ rights are strengthening in many Latinx cultures, many barriers still exist in the form of religious beliefs that are anti-LGBTQ+ and systemic anti-LGBTQ+ bias (e.g. discrimination in healthcare, school settings, legal settings).

In the U.S., LGBTQ+ Latinx people face growing discrimination. Immigration has taken a central role in national dialogue, as certain regions of the country have passed laws aimed at preventing Latinx migration into the U.S. in general as well as deporting immigrants from Mexico specifically. Latinx people in the U.S. can also face an environment in which they are even more subject to suspicion, discrimination, and certain deportation. Therefore, anti-immigrant sentiment can influence all Latinx people regardless of their citizenship status or country of origin; and Latinx LGBTQ+ people seeking asylum can be some of the most vulnerable as they may be experiencing intense anti-LGBTQ+ bias in their home countries and face additional barriers when attempting to gain asylum. In addition to the changing climate, Latinx LGBTQ+ people may face barriers within both white and Latinx communities when traditional roles are rigidly followed. As with any group, it is important to be aware of the current political and cultural climate when working with Latinx LGBTQ+ couples and families; yet, individual differences must be considered.

Asian American and Pacific Islander LGBTQ+ Partners and Families AAPI LGBTQ+ partners and families, like other ethnic minority groups, face several societal stereotypes as they attempt to lead fulfilling lives. One of the most pervasive stereotypes is the "myth of the model minority," that is, the idea that AAPI people have success at higher rates than do other ethnic minority groups (Singh, 2009). This stereotype creates additional pressure on LGBTQ+ partners and families because they not only have to navigate societal heterosexism but also feel pressure to be perfect as they do so.

As a result, these partners and families may not feel able to openly share the actual stressors in their lives for fear of losing face (Zane & Yeh, 2002). *Losing face* is a cultural concept that refers to the importance of maintaining privacy about personal, professional, and/or family struggles, in addition to presenting an optimistic view of life. Often intersecting with the important notion of face is the cultural value that hierarchy of family relationships is paramount. For instance, there might be cultural traditions and assumptions that aging parents will be taken care of by their children in their family homes, whereas securing assisted living for aging parents would be culturally frowned upon or even considered unacceptable. A loss of face can also include an experience of shame that can shape the decisions of LGBTQ+ couples and families about the extent of which they decide to share their LGBTQ+ identities with their families of origin.

Cultural traditions and belief systems, including respect for one's parents, are often strong AAPI values that may influence how AAPI partners and families experience stressors and show resilience around their presenting concern in therapy (Singh, 2009). Therefore, in addition to understanding that there are varying views of sexual orientation and gender identity and expression within AAPI cultures, affirmative practitioners need to understand that the degree of importance AAPI partners and families may put on coming out to their families of origin may likewise vary. In addition, the myth of the model minority may make AAPI partners and families feel that their disclosure of an LGBTQ+ identity may cause their families to lose face in their communities. Therefore, it is never appropriate for practitioners to pressure LGBTQ+ partners and families to disclose their identities. Rather, it is more helpful to explore the stressors and resilience they experience with regard to their families and seek to connect them with other examples of AAPI partners and families (e.g. through community or social organizations and/or Internet resources).

Indigenous LGBTQ+ Couples and Families Indigenous people face a great many challenges in U.S. society. Many factors are important in considering the experiences of Indigenous people, such as whether they live or have lived on or off a reservation; which tribe or tribes they are from; whether they follow Christian practices, traditional spiritual practices, another spiritual or religious path, or none at all; their experiences with alcohol and drugs and other risk factors/negative outcomes, whether for the self or the family; their racial identity development; their class status; what languages they speak; and so on. There are hundreds of tribes who survived the genocide brought on by whites of European descent through the process of colonization, and each tribe has a unique set of beliefs, practices, and traditions as well as variation in adherence to those practices and degree of assimilation in or acculturation to white culture. The oppression and marginalization of Indigenous people have continued since whites first invaded the Americas, as evidenced by the continued high rates of suicide, alcoholism, poverty, and other social problems that Indigenous people face in many tribal communities. One means of continuing to marginalize Indigenous peoples is the construction of the term *Native American*, which in the U.S. ignores Indigenous peoples of Mexico and Canada who are not included in this definition despite the number of people living in the U.S. that originate from lands now known as Mexico and Canada (e.g. Aztec, Mayan, Cree, Micmac, and Squamish). Indigenous identity has been historically constructed in a manner that is consistent with early attempts to assimilate and exterminate Indigenous peoples. This narrative goes so far as to often include language that reflects inaccurate notions about the "extinction" of these tribes by referring to them in the past tense.

Indigenous people have strong historical traditions that include positive spaces for LGBTQ+ people, referred to by as many different names as the tribes they come from, among them Nahdlee (Dine) Iskwêhkân (Cree), Ikwekaazo (Ojibwe), or Winkte (Lakota). In 1990, the term *Two Spirit* was coined during the third annual intertribal Native American, First Nations gay and lesbian American conference in Winnipeg (North American Aboriginal Two Spirit Information Pages; see Indian Health Service, n.d.). *Two Spirit* is an intertribal word that includes the complex intersections between gender and sexuality and was used as a means of community building between LGBTQ+ people of many different tribes. The use of this term represents a new tradition, yet it is a new tradition that honors and revives older traditional conceptions of the many different ways that gender and sexuality were constructed across tribes. Although Indigenous people have had strong histories of honoring LGBTQ+ folx, they are not immune to modern homoprejudice, biprejudice, aceprejudice (prejudice against asexual people), and transprejudice. The consistent attempts to assimilate Indigenous people have infused these forms of oppression into modern life.

It is important when working with LGBTQ+ Indigenous families and couples for affirmative practitioners to understand the cultural context of family. Although the scope of this chapter precludes space to review the intergroup differences in depth, there are some differences that might be helpful to consider. In any situation, individual differences should be considered in understanding any couple or family's unique construction. One consideration is the importance of extended families that may or may not include nonbiological family members. Another consideration is the child-rearing principle of noninterference. This principle, practiced by many Indigenous people, describes a process through which adults allow children to make mistakes (instead of parents immediately correcting behavior) in order to allow the children's unique personalities and life paths to emerge without undue influence from others.

A final important consideration is the role of the mental health profession in the oppression of Indigenous people and LGBTQ+ people. The mental health profession has historically been used in ways that have served to perpetuate the oppression of both of these groups (e.g. conversion or reparative therapy and the role of child and family services in the removal of Indigenous children from the home and subsequent placement of those children in white homes until the Indian Child Welfare Act); therefore, building a trusting relationship in the therapeutic context may be challenging (Sue & Sue, 2007). Allowing for the use of nontraditional methods and theoretical frameworks (e.g. the integration of spiritual leaders into the sessions), as well as the inclusion of extended families as desired by the family or couple, may be particularly important.

White LGBTQ+ Couples and Families When considering the racial identity of white people, it is important to consider the experiences of privilege held by whites in U.S. society. As described by Peggy McIntosh (1989), whites experience daily privileges that are not shared by people of color. In considering how these privileges are experienced by LGBTQ+ individuals, the intersection of privilege and oppression is particularly important (Singh et al., 2017). For example, while LGBTQ+ people face daily oppressions based on their sexual orientation and gender identity, white LGBTQ+ people have added advantages not experienced by LGBTQ+ people of color. An example of this is in the number of white LGBTQ+ characters found in television shows and movies compared to the number of LGBTQ+ people of color. Another example of this intersection is found particularly in smaller communities, where LGBTQ+ communities are largely made up of white members, and their concerns are given particular weight over those of their counterparts. Similarly, the face of the LGBTQ+ rights movement pivots on white figures and white concerns. A poignant example of this intersection of privilege and oppression is found in the number of white LGBTQ+ suicides that have gained national attention recently, which have significantly impacted media coverage of bullying toward LGBTQ+ youth in schools and universities. The increased coverage of LGBTQ+ bullying is of course important—at the same time, LGBTQ+ people of color become invisible in these campaigns. This invisibility is problematic, especially considering that Native Americans have the highest suicide rates in the U.S., with a 139% increase from 1999 to 2017 (Curtin & Hedegaard, 2019); this fact, though, is not reflected in the national media reporting on LGBTQ+ bullying.

In working with white LGBTQ+ couples and families, it is important to not over- or underestimate the interplay between privilege and oppression. For example, it would be discriminatory and unwise to pay sole attention to the suicide risk of whites but equally dangerous to ignore it. Another important consideration is how white privilege is gendered (i.e. the intersection between male privilege and white privilege). Male privilege is experienced by gay and bisexual men differently than by their straight counterparts. For example, a large part of male privilege is exclusive to straight men because the definition of *man* is binary and contingent upon the oppression and objectification of women. Gay and bisexual men who are more feminine will experience this even more acutely because traditional masculinity is required for the

full assumption of male privilege. In the same vein, transgender and nonbinary individuals are also excluded from many aspects of white privilege because of the strict binary assumptions of gender.

Multiracial LGBTQ+ Couples and Families Just as we discuss the various racial and ethnic groups, it is also important to acknowledge that multiracial partners and families exist and have unique counseling needs. Although race and ethnicity may not be the focus of their presenting concerns, it is important to thoroughly assess their experience of racial and ethnic identity. For instance, a bisexual partner with an AAPI maternal family and an African American paternal family may have been raised to value one racial or ethnic identity over another or to value both equally; however, they may have been raised not to think about race at all. No matter how the individual's experience of racial and ethnic identity was shaped within the family, it is important to explore both past and present experiences within and outside the individual's family to explore the development of their racial and ethnic identity.

Racial and ethnic identity has several components, including how one is perceived by others and how one perceives oneself as a racial and ethnic being. Therefore, a component of healing and understanding for multiracial people may entail exploring how their racial and ethnic identity development has influenced their values and worldviews, as well as how these aspects translate into their intrapersonal and interpersonal relationships. Root (1996) has written extensively on multiracial counseling, and a large component for practitioners is to explore and validate partners' and families' experiences of race and ethnicity as opposed to reinforcing racial and ethnic stereotypes these individuals may have experienced growing up (e.g. "You don't look Asian American").

Case Study 2: Out for the Holiday

Marcus, aged 41, is a Black, bisexual man. He currently works as a general manager at a local grocery store in town. He is active in the LGBTQ+ community and is out in many contexts, but he is not out to his family. He is also an active member in his church, which is not supportive of same-sex relationships. Marcus grew up in a working-class family, where his mother supported him and his three siblings with help from his grandmother. Marcus has not had contact with his father since he was 11 years old, when he and his mother divorced. Marcus and Minsoo met at college. They began dating after meeting in a college class and have been together for 18 years. Minsoo is Marcus's first same-sex partner, but Minsoo has been dating men only since he was in high school.

Minsoo, age 39, is a Korean American who identifies as gay. He has a master's degree in elementary education and works at an elementary school as a teacher. Minsoo grew up in an upper middle-class family with his mother, father, and three older brothers. His family members are Buddhists from a small South Korean community nearby. They are supportive of Minsoo's identity but have trouble accepting his relationship with Marcus because of Marcus's race.

Marcus and Minsoo have come to therapy to address their growing concerns related to intimacy and conflict related to the pressure Marcus feels from Minsoo to come out to his family. Marcus and Minsoo report that after an increase in bias incidents and hate crimes in their community recently, including a situation in which two gay men were beaten severely by a group of male college students on campus at a party, their own sense of safety has been shaken. They report that they experience more intimacy when they are able to spend time together at LGBTQ+ events or with supportive friends in the LGBTQ+ community. However, even this has begun to change as the holidays are approaching because Minsoo has been insistent that Marcus come out to his family so they can spend the holidays together as partners.

Marcus feels that Minsoo does not understand how much he fears coming out to his family, and how much he has to lose if he comes out and, as he suspects, it does not go well. Marcus is worried his family will disown him. In addition, he is worried that it might jeopardize his role in church, where he spends a significant amount of time, because they church is intolerant of homosexuality and his mother is also very active and involved their lives. Minsoo feels that Marcus's resistance is related to his bisexual identity, such that he is hesitant to commit to a same-sex relationship because he is holding onto what is left of his straight privilege. Minsoo reports that Marcus has told him he would come out to his family before this coming holiday, but that now he is backing down. Minsoo is concerned that if they cannot be out and proud as a couple, then their relationship will not last. Marcus is already uncomfortable when they visit Minsoo's family because he can tell that they do not accept his race/ethnicity. He believes that coming out to his own family will not actually allow them to spend the holidays together comfortably with either family since neither is likely to fully accept the couple.

Potential Strategies and Considerations

An important first consideration for this case is to acknowledge the mounting challenges that Marcus and Minsoo face while simultaneously building on their strengths as partners. There are many opportunities for self-reflection as a therapist (e.g. "How does my religion or identity as an atheist or agnostic person influence how I see religion and spiritual beliefs in this couple?," "How does my sexual orientation and gender identity development influence how I view the presenting issue?," "How might my racial/ethnic identity influence my work with Marcus and Minsoo?"). Oftentimes it is easy to assume that people who have partners from different backgrounds than themselves are automatically knowledgeable and understanding of the differences in their lived experiences. In this case, however, it may be particularly helpful to spend time helping each partner to understand some aspects of how they uniquely experience oppression in the world (e.g. discussing biprejudice and also the role of the church community in Black identity, or the role of class privilege paired with queer identity, or the differences between Christian and Buddhist upbringing and how Christian privilege may play a role in their relationship as it relates to religion and "the holidays").

In addition, helping this couple collectively explore the role that oppression may have in their intimacy will be especially important. For example, once the therapist has helped both to explore and to express how they experience oppression uniquely, the therapist might ask the couple to explore what types of feelings are present when they experience oppression and further how those feelings influence their intimacy with one another. As the upcoming holidays approach, it will be important to help this couple to identify rituals and traditions that can bring them together in conjunction with helping them navigate their relationships with family and what that means to them as partners. Below is an example of how this session may look:

Therapist: One thing that might be helpful in our time together is to explore the different ways that you each specifically experience oppression. Marcus, can you share something with Minsoo about how you experience biprejudice in the world?

Marcus: Sure. Well, one thing that stands out is that often my identity is seen as not real because people assume that I will just eventually date a woman, and somehow will cease to be a part of the LGBTQ+ community.

Therapist: Can you tell Minsoo how this might play out in your relationship?

Marcus: Well, Minsoo, I think that sometimes you assume me not coming out is because I am not fully part of the community because I am bi.

Minsoo: I guess I can see what you mean, but for me, there hasn't been an option to stay in the closet with any of my partners.

Therapist: Do you think that these oppressions we have been exploring have an impact on your desires to connect with each other and for intimacy within your relationship?

Minsoo: For me it has, for sure. I think I have been feeling resentment about not being able to be together for the holidays as a couple. And because of that, I find myself pulling away sometimes.

Therapist: And you, Marcus?

Marcus: I am not sure. I think the pressures about it all in general just make me feel stressed. Sometimes it can be easier to just focus on something outside of us when I feel that way, so I guess, yeah…I do experience that.

Intake Session

Even before the intake session, practitioners should be able to communicate with clients and begin to share the particular therapy approach and commitment to multicultural practice and concerns related to social justice. In the intake session itself, practitioners should conduct a "cultural formulation," that is, an assessment of the partners' or families' value systems related to their cultural background and salient identities. Rather than merely obtaining brief answers to these questions, practitioners can ask clients what the meaning and awareness of their background and identities hold for them. It is also important to ask specific questions about experiences with systems of oppression (e.g. racism and sexism), in addition to how these systems may influence individual, partners', and families' well-being and the presenting concern for therapy.

In the exchange between Marcus and Minsoo, before we would be able to explore their specific experiences of oppression, we would need to assess their awareness around systems of privilege and oppression and their own experiences situated within these. Where a couple is lacking in information, the therapist might provide some bibliotherapy or explore these concepts in session in order to incorporate them more fully. When working with individuals who are early in their identity development(s), their awareness about their oppression may be minimal so this process may take some time, and the therapist would need to be gentle about introducing too many new awarenesses at once. In addition, role-play exercises that explore how it feels to share one's sexual orientation with family that may not be supportive during the holidays can help the therapist draw out real-life considerations of disconnection, loss, and grief that are influencing their communication and shared decision-making as a couple. Ultimately as the therapist, the goal is to provide empathy, compassion, and validation of how societal oppression influences the resilience, connection, and shared love that Marcus and Minsoo get to experience with one another. These role plays can also help explore what existing community resources and support might be available to them to decrease the isolation and stress that they are experiencing as an LGBTQ+ couple and help provide examples and encouragement of how to navigate the holidays.

Assessment of Trauma

Every good intake includes a trauma assessment. With counseling of diverse LGBTQ+ partners and families, however, it is important not only to ask specific questions about experiences of trauma but also to understand how these experiences may be related to systems of oppression. This trauma assessment should be ongoing throughout the course of therapy. Because of the high rates of oppression that diverse LGBTQ+ persons in general experience, understanding these critical incidents will help practitioners understand the presenting issue and course of therapy more effectively, in addition to being able to collaboratively identify healthy

and unhealthy coping developed in partnerships and families as a result of these experiences. While the trauma assessment may stand out more in the first case, it is equally important in the case between Marcus and Minsoo. In particular, a therapist might want to ask about trauma not only related to being LGBTQ+, but also as men of color and within their individual religious traditions. Possible experiences of trauma could relate to their gender, sexuality, race, and/or religion or any combination and therefore, could include or relate to issues of systemic oppression.

Conclusion

This chapter has discussed the major factors practitioners should consider when working with diverse LGBTQ+ partners and families. Overall, an attention to multicultural competence and awareness of social justice issues that influence the lives of these partners and families are paramount. Because these partners and families must negotiate not only experiences of heterosexism, homoprejudice, and transprejudice but also other systemic oppressions, it is important to use a multicultural and social justice lens through which to view clients' presenting issues in addition to an ongoing attention to therapist assumptions and biases based on the therapist's own cultural background and experiences of privileged and oppressed identities.

References

Anglin, D. M. (2006). Shifting: The double lives of Black women in America. *Journal of Black Psychology, 32*(3), 390–394. https://doi.org/10.1177/0095798406290471

Atkinson, D. R., Morten, G., & Sue, D. W. (1989). A minority identity development model. In D. R. Atkinson, G. Morten, & D. W. Sue (Eds.), *Counseling American minorities* (pp. 35–52). W. C. Brown.

Bleiberg, S., Fertmann, A., Friedman, A. T., & Godino, C. (2005). The layer cake model of bisexual identity development: Clarifying preconceived notions. *Campus Activities Programming, 38*(1), 59–62.

Bowleg, L., Huang, J., Brooks, K., Black, A., & Burkholder, G. (2003). Triple jeopardy and beyond: Multiple minority stress and resilience among Black lesbians. *Journal of Lesbian Studies, 7*(4), 87–108. https://doi.org/10.1300/J155v07n04_06

Brown, T. (2002). A proposed model of bisexual identity development that elaborates on experiential differences of women and men. *Journal of Bisexuality, 2*(4), 67–92. https://doi.org/10.1300/J159v02n04_05

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review, 43*(6), 1241–1299. https://doi.org/10.2307/1229039

Cross, W. E., Jr. (1991). *Shades of Black: Diversity in African American identity*. Temple University Press.

Curtin, S. C., & Hedegaard, H. (2019). *Suicide rates for females and males by race and ethnicity: United States, 1999 and 2017*. National Center for Health Statistics.

D'Amico, D. (2003). *Race, class, gender, and sexual orientation in adult literacy: Power, pedagogy, and programs* (Vol. 4, chapter 2, pp. 17–69). http://www.ncsall.net/fileadmin/resources/ann_rev/rall_v4_ch2.pdf

Family Equity. (2008, February 19). *Recent statistics: Hispanic lesbian and couples adopt at higher rate than other same-sex couples.* https://www.familyequality.org/2008/02/19/recent-statistics-hispanic-lesbian-and-couples-adopt-at-higher-rate-than-other-same-sex-couples/

Frey, W. H. (2018). *The US will become 'minority white' in 2045, census projects: Youthful minorities are the engine of future growth.* https://www.brookings.edu/blog/theavenue/2018/03/14/the-us-will-become-minority-white-in-2045-census-projects/

Gates, G., (2012). Same-sex couples in census 2010: Race and ethnicity. *The Williams Institute*. https://escholarship.org/uc/item/66521994

Green, R. J., & Mitchell, V. (2002). Gay and lesbian couples in therapy: Homophobia, relational ambiguity, and social support. In A. S. Gurman & N. S. Jacobson (Eds.), *Clinical handbook of couple therapy* (3rd ed., pp. 546–568). Guilford.

Harper, A. J., & Swanson, R. (2019). Nonsequential task model of bi/pan/polysexual identity development. *Journal of Bisexuality, 19*(3), 337–360. https://doi.org/10.1080/15299716.2019.1608614

Helms, J. E. (1995). An update of Helms's white and People of Color racial identity models. In J. Ponterotto, M. Casas, L. Suzuki, & C. Alexander (Eds.), *Handbook of multicultural counseling* (pp. 181–198). Sage. https://doi.org/10.1037/t47453-000

Indian Health Service. (n.d.). https://www.ihs.gov/lgbt/health/twospirit/

Jordan, K. M., & Duluty, R. H. (2000). Social support, coming out, and relationship satisfaction in lesbian couples. From nowhere to everywhere: Lesbian geographies. *Journal of Lesbian Studies*, *4*(1), 145–164. https://doi.org/10.1300/J155v04n01_09

Klar, N. (1993). *What was the role of the church in the conquest and colonization of Latin America? Did it vary in different areas and was there a true spiritual conquest?* http://klarbooks.com/academic/catholic.html

Klein, F. (1993). *The bisexual option* (2nd ed.). Hawthorn Press.

Locke, D. C., & Bailey, D. (2014). Increasing multicultural understanding (3rd ed., pp. 105–134). Sage. https://doi.org/10.4135/9781483319582

Lodola, G., & Corral, M. (2010, July 22). Latin America's support for same-sex marriage. *Americas Quarterly*. http://www.americasquarterly.org/node/1728

Mather, M., Jacobsen, L. A., Jarosz, B., Kilduff, L., Lee, A., Pollard, K. M., Scommenga, P., & Vanorman, A. (2019). *Population reference bureau's exclusive preview of the upcoming decennial census reveals population shifts with major implications for the nation's political, social, and economic future.* https://www.prb.org/what-the-2020-u-s-census-will-tell-us-about-a-changing-america/

McIntosh, P. (1989, July–August). White privilege: Unpacking the invisible knapsack. *Peace and Freedom*.

Meyer, I. H. (2015). Resilience in the study of minority stress and health of sexual and gender minorities. *Psychology of Sexual Orientation and Gender Diversity, 2*(3), 209–213. https://doi.org/10.1037/sgd0000132

Miller, S., & Parker, B. A. (2009). Reframing the power of lesbian daughters' relationships with mothers through Black feminist thought. *Journal of Gay & Lesbian Social Services: Issues in Practice, Policy & Research, 21*(2–3), 206–218. https://doi.org/10.1080/10538720902772105

Poston, D. L. Jr., & Saenez, R. (2017, August 8). U.S. whites will soon be the minority in number, but not power. *Baltimore Sun*. https://www.baltimoresun.com/opinion/op-ed/bs-ed-op-0809-minority-majority-20170808-story.html

Poston, W. S. C. (1990). The biracial identity development model: A needed addition. *Journal of Counseling and Development, 69*(2), 152–155. https://doi.org/10.1002/j.1556-6676.1990.tb01477.x

Poynter, K. J., & Washington, J. (2005). Multiple identities: Creating community on campus for LGBT students. *New Directions for Student Services, 2005*(111), 41–47. https://doi.org/10.1002/ss.172

Ratts, M., Singh, A. A., McMillan-Nasser, S., Butler, S. K., & McCullough, R. (2016). Multicultural and social justice competencies: Guidelines for the counseling profession. *Journal of Multicultural Counseling and Development, 44*(1), 28–48. https://doi.org/10.1002/jmcd.12035

Root, M. P. P. (1996). *The multiracial experience: Racial borders as the new frontier*. Sage. https://doi.org/10.4135/9781483327433

Root, M. P. P. (2003). Racial identity development and persons of mixed race heritage. In M. P. P. Root & M. Kelley (Eds.), *Multiracial child resource book: Living complex identities* (pp. 34–41). MAVIN Foundation.

Schlosser, L. (2003). Christian privilege: Breaking a sacred taboo. *Journal of Multicultural Counseling and Development, 31*(1), 44–51. https://doi.org/10.1002/j.2161-1912.2003.tb00530.x

Singh, A. A. (2009). Counseling with Asian Americans. In C. M. Ellis & J. Carlson (Eds.), *Cross cultural awareness and social justice in counseling* (pp. 147–167). Taylor & Francis.

Singh, A. A. (2010). It takes more than a rainbow sticker! Using the ACA advocacy competencies with queer clients. In M. Ratts, J. Lewis, & R. Toporek (Eds.), *Using the ACA advocacy competencies in counseling* (pp. 29–41). American Counseling Association.

Singh, A. A., & Chun, K. S. Y. (2010). From "margins to the center": Moving towards a resilience-based model of supervision for queer people of color supervisors. *Training and Education in Professional Psychology, 4*(1), 36–46. https://doi.org/10.1037/a0017373

Singh, A. A., Hays, D. G., & Watson, L. S. (2011). Strength in the face of adversity: Resilience strategies of transgender individuals. *Journal of Counseling & Development, 89*(1), 20–27. https://doi.org/10.1002/j.1556-6678.2011.tb00057.x

Singh, A. A., Hwhang, S., Chang, S., & White, B. (2017). Affirmative counseling with trans/gender-variant people of color. In A. A. Singh & L. M. Dickey (Eds.), *Trans-affirmative counseling and psychological practice* (pp. 41–68). American Psychological Association. https://doi.org/10.1037/14957-003

Singh, A. A., & Salazar, C. F. (2010). Six considerations for social justice group work. *Journal for Specialists in Group Work*, *35*(3), 308–319. https://doi.org/10.1080/01933922.2010.492908

Sue, D. W., Arredondo, P., & McDavis, R. J. (1992). Multicultural counseling competencies and standards: A call to the profession. *Journal of Counseling & Development, 70*(4), 477–486. https://doi.org/10.1002/j.1556-6676.1992.tb01642.x

Sue, D. W., & Sue, D. (2007). *Counseling the culturally diverse: Theory and practice* (5th ed.). Wiley.

Toporek, R. L., & Daniels, J. (2018). *2018 update and expansion of the 2003 ACA advocacy competencies: Honoring the work of the past and contextualizing the present*. https://www.counseling.org/docs/default-source/competencies/aca-advocacy-competencies-updated-may-2020.pdf?sfvrsn=f410212c_4

U.S. Census Bureau. (2018). *Quick facts.* https://www.census.gov/quickfacts/fact/table/US/RHI225219

Werner-Wilson, R. J., Zimmerman, T. S., & Whalen, D. (2000). Resilient response to battering. *Contemporary Family Therapy, 22*(2), 161–188. https://doi.org/10.1023/A:1007777702757

Zane, N., & Yeh, M. (2002). The use of culturally-based variables in assessment: Studies on loss of face. In K. S. Kurasaki, S. Okazaki, & S. Sue (Eds.), *Asian American mental health: Assessment theories and methods. International and cultural psychology series* (pp. 123–138). Kluwer Academic/Plenum Publishers. https://doi.org/10.1007/978-1-4615-0735-2_9

3
Heteronormativity and Ethics in the Treatment of LGBTQ Clients

MEGAN J. MURPHY

Critique of Current Ethical Practices

Ethics is truly foundational in the practice of therapy as clinicians routinely weigh the therapeutic implications of ethical decision-making. When an ethical dilemma presents itself, we turn to our professions' codes of ethics to help provide guidance and clarity about what is generally agreed upon to be right and good clinical practice. This is considered especially important in fields like mental health where the clinician is imbued with the power and authority that comes with an advanced degree and a professional license.

Yet, this general approach to ethics—while considered good practice—is highly problematic for two reasons: it relies on the clinician to detect ethical dilemmas, and it focuses on the situational instead of the relational. These two intertwined problems result in a dichotomization of the ethical process—therapist versus client, ethical dilemma versus therapy-as-usual, with a minimization of power and context. This traditional approach to ethics and the dichotomies it produces uphold the status quo and are especially problematic for marginalized people as they underlie many harmful "isms," including heterosexism, sexism, racism, classism, and so forth. The blind spots which stem from this stance are especially salient to the field of marriage and family therapy, which purports to value and prioritize the relational.

Initially, it makes sense for the clinician to be the one to make ethical decisions when an ethical dilemma arises. After all, the clinician is the one responsible for being ethical. However, that a dilemma or issue is detected by the clinician necessarily centers the decision-making power on the clinician, with little to no room for the client's voice or active participation. Most ethical decision-making models minimize the importance of working with the client to address and remediate an ethical issue that arises (or even prevent an ethical issue from emerging in the first place). Currently, decisions being made rely on the individual practitioner without requirement of contextual considerations, consultations with others, nor collaboration with the larger community (Hancock, 2014). As a result, there is tremendous variance in what are presumed to be equally equivalent ethical and moral decisions.

Ethical decision-making also focuses on the situational instead of the relational. Ethical challenges are viewed as arising idiosyncratically, and are seen as isolated events that need resolving, separate from the therapeutic relationship. Using ethical decision-making to resolve a dilemma negates the relational realm from which ethical situations emerge. It is further implied that once an ethical dilemma is resolved, the clinician can then resume therapy-as-usual until the next ethical dilemma presents itself.

Ironically, the field of marriage and family therapy, which has a systemic/relational focus, has a code of ethics that centers individual, acontextual considerations which is highly problematic in the pursuit of justice for LGBTQ clients. Each profession's codes of ethics are created by professionals who are already in the field, and are very likely to be predominantly white, cisgender, heterosexual, middle- to upper-class Christian men. As a result, professions' codes of ethics

DOI: 10.4324/9780429274626-5

standards reflect the interests of these dominant groups; that is, the codes of ethics are likely to uphold the status quo that benefits these groups. Changes to the codes of ethics depend upon the composition of professionals who are charged with updating the codes—a process that can be utterly opaque especially to minoritized members of a field who are often not included in primary revisions to the ethics codes. Different professions have different codes of ethics in part because they have different foci—the field of family therapy highlights systemic and relational concerns, whereas mental health counselors focus on individuals and groups. Yet, the fields have different codes of ethics also because each field has a different level of openness to critique and new ideas, which again may be reflective of the demographic composition of the leaders in the field, and may also be tied to the history/development of the field.

The centering of white supremacist, sexist, euro-centric colonialism imbued in the profession's code of ethics is hard to challenge or even acknowledge because it reflects the values of the culture in which we live. We cannot separate the therapeutic charge nor consideration of ethics from the sociocultural political landscape of the country. Yet, our codes of ethics (American Association for Marriage and Family Therapy, 2015; hereafter referred to as AAMFT Code of Ethics) are resoundingly silent about these factors that shape our relational work. Nowhere in the AAMFT Code of Ethics are heteronormativity, patriarchy, racism, or misogyny implicitly or explicitly addressed; however, it does address nondiscrimination, and places it first (Standard 1.1). As related to LGBTQ clients in particular, ethics codes' nondiscrimination standards include sexual orientation, gender, gender identity, relationship status, and other intersectional identities such as age, race, religion, and disability. Yet, the code of ethics is bound by restrictions complicating the implementation of protections against discrimination. There are many ways around having to uphold this standard, including federal and state laws, accreditation standards and exemptions therein, and program practices that allow for and justify students and faculty to discriminate.

Furthermore, all ethical decision-making models include consideration of ethical principles of autonomy, beneficence, nonmaleficence, justice, fidelity, and veracity. The decision-making models we learn about and rely on call for us to consider these principles when making ethical decisions; however, the way we weigh and prioritize these principles—which is inevitably culturally bound—has direct implications for the decisions that are made, and the view of the resulting decisions as ethical or not. There is little guidance on how to weigh these ethical principles especially when they conflict or contradict one another. As a result, we are inclined to believe that we are being neutral, and therefore ethical—when we are not being neutral and are only being ethical to the extent that we are adhering to the status quo.

Autonomy is an ethical principle that frequently appears in writing about ethics related to LGBTQ populations. No one would argue the importance of self-determination for clients in deciding what is best for themselves; autonomy plays a key role in the informed consent process as well. Clients have the right to know about the benefits and risks of therapy so that they can make a fully informed decision. However, autonomy considered by itself and without context can risk harming the individual and/or the relationships and community in which they are embedded. Currently, we see this dilemma and its downside playing out with the debate about wearing masks during the COVID-19 pandemic. Many individuals in U.S. society have exerted their autonomy in deciding for themselves that they will not wear a mask. However, a non-relational hyper-focus on autonomy inherently negates the relational and the communal; deciding not to wear a mask may not only have negative implications for oneself; it has negative implications for those immediately around the individual (those in direct relationship with the individual) as well as for the community at large.

Similarly, when clinicians make decisions that impact others, they are likely not to embrace a pure approach to autonomy; instead, what is called for is the consideration of larger systems

and impacts, along with collaboration with clients to the greatest extent possible, as well as an accountability to multiple groups, including but not limited to professionals in the field, members of the clients' multiple communities, and those they are in relationship with.

All of which is to say that heteronormativity is found throughout our ethical practices, including the codes of ethics, ethical principles, and our decision-making models. We need to be able to continually question our ethical practices, principles, and beliefs. The change starts with us; therefore, we must ask ourselves: what ethics are we upholding when we work with clients? What value systems are we centering and what blind spots are we reproducing in our clinical work?

Shifting to Relational Ethics

Relational ethics center the relational instead of the individual. Here, ethics are viewed as inherently relational, as moment-to-moment and ever-shifting. Each of us in relationship is always contributing to some understanding—of ourselves, of the other, and of the relationship. Each act and each utterance has ethical and moral implications for ourselves and others—others both at the individual level and at the communal/societal level. Here, identity is crucial, both in display of self and in connection with the other; ethics are personal to who we are as well as who the other person is, as well as the communities of which we are both a part. Relational ethics provides a beginning step into acknowledgment of and grappling with the power dynamics that inevitably permeate all relationships, including therapeutic relationships. Key features of relational ethics include the consideration of context as well as the social responsibility we have to self and others (Haslebo & Haslebo, 2012). In writing about relational ethics, Shaw (2011) says, "Relationship based ethical approaches argue that the individualistic, rationalistic dominant discourse has left out the moral wisdom of narrative, interpersonal, and community elements" (p. 2). She goes on to describe relational ethics as "encompassing the territory in which people come to reflect about and decide on their obligations and responsibilities to self and other" (p. 2).

It is difficult to overstate the difference of a relational approach to ethics compared to the traditional view reflected in the codes of ethics developed by specific mental health professions. First, a focus on relationship calls for participation of both the therapist and the client(s) in considering responsibilities each has toward the other. Codes of ethics are designed by professional organizations for use by therapists in guiding their behavior and conduct with clients; overall, the goal is protecting clients from harm. One challenge with the code of ethics is that it is designed for use by therapists in making determinations about what is ethical for clients. This rational, hierarchical approach is considered to be so "normal" as to go unquestioned; indeed, to question or critique the code of ethics may be to be accused of being entirely unethical. What if the focus was on the relational? Relational ethics invites therapists into dialogue with clients about the ethical questions that arise both in the therapeutic relationship and in the relationship both therapist and client(s) have with the broader community while considering the power both have to shape the relationship. From an individualistic ethics view, we are caught in a conundrum of how to respond to questions that focus on an individual—the therapist or the client—but neither together in relationship nor considering the communities in which the individuals and the relationships reside.

Although relational ethics offers a paradigm shift in thinking about, practicing, and *doing* ethics, individual participants who employ relational ethics still suffer from the same blind spots that more traditional ethics evokes; the therapist (who has the most power in the therapeutic encounter) will have to actively resist heteronormativity in the practice of therapy. The risk from a relational ethics view is in defaulting to the status quo; the therapist (and the client) will need to work together to name and address heteronormativity when it arises. The onus is on the therapist as a person in position of power to place resistance at the forefront of the therapeutic encounter.

Common Ethical Issues in LGBTQ-Affirmative Therapy

In reviewing the literature on ethics working with LGBTQ clients, several issues consistently emerge that underscore the influence of heteronormativity in ethical considerations: conversion therapy, training issues and gatekeeping, referring clients out, and affirming trans identities. I explore each of these issues within a frame that considers the influence of heteronormativity and ethical decision-making, which includes the AAMFT Code of Ethics and ethical principles.

Conversion Therapy

In writing about conversion therapy, even in criticizing its ethics, I fear contributing to the discourse of its legitimacy. Yet, the harm in ignoring the reality that the merits of conversion therapy are still being debated is greater than the benefits of addressing it here in this chapter precisely because powerful interests continue to support this approach and therefore it continues to be practiced. That we continue to consider "treating" homosexuality or that some family therapists are supporting the benefits and merits of conversion therapy (Rosik, 2003) directly speaks to the pervasive heteronormative cultural context in the United States (and in other countries). Indeed, McGeorge and colleagues (2015) found that therapists with more negative beliefs about LGB individuals are more likely to believe in the ethics of conversion therapy, as well as to practice conversion therapy.

Unfortunately, the AAMFT Code of Ethics (2015) can readily supply support to the legitimacy of conversion therapy by neutrally presenting a standard that purports to equally address various forms of possible discrimination (Gamboni et al., 2018). Standard 1.1 Non-Discrimination states, "Marriage and family therapists provide professional assistance to persons without discrimination on the basis of race, age, ethnicity, socioeconomic status, disability, gender, health status, religion, national origin, sexual orientation, gender identity or relationship status." The ethical dilemma often presented in relation to conversion therapy places sexual orientation and religion—two characteristics in the standard—in direct conflict. Many arguments can and have been made as to which "side" has more legitimate claim to an ethical position. Put simply, the heart of the dilemma is whether conversion therapy is a legitimate form of therapy that can be provided to relieve clients/people of their same-sex attractions. This question itself neglects the often religious, heteronormative assumptions behind the question, which may not be legitimately debated, lest an argument of religious discrimination be made in even raising these questions. There is no direction provided for an ethical resolution if one only relies on the AAMFT Code of Ethics; and because the Code of Ethics reflects the profession's heteronormativity (and racism, sexism, and other isms), the neutral default results in an upholding of a heteronormative view of this issue that provides power and legitimacy to one side of the issue.

Ethical decision-making models, which all cite the importance of weighing the ethical principles, provide general guidance but no direction, with the same resulting default of upholding heteronormative assumptions. Autonomy—the bedrock of ethical principles—calls for the client's right to make decisions for themselves. Clients may seek therapy to change their sexual orientation. From a context-free understanding of autonomy, a therapist could argue that a client is entitled to decide for themselves that they want to be rid of homosexual desires. A therapist's support for any other decision could be seen as the therapist imparting their values onto the client. Professionals can and do make these arguments in deciding to provide conversion therapy to clients. Yet, a context-free view of autonomy fails to consider the therapist's own values in supporting the treatment, and demonstrates an inattention to larger communities' views on the value of conversion therapy.

That is, autonomy itself exists in context and in a community; many clients come to therapy for help on various issues that a therapist may not support, such as a client seeking to maintain

behaviors consistent with anorexia (Green, 2003). Nonmaleficence must be considered when deciding the ethics of providing conversion therapy to clients who request it. There is much research to support the negative impacts of heterosexism, minority stress, and discrimination on LGBTQ-identified clients (Ranade & Chakravarty, 2016). Therapists must be aware of the suicide statistics for those who identify as LGBTQ—they are significantly higher than in the non-LGBTQ population (Dopp, 2013). Given these statistics, conversion therapy cannot be seen as an appropriate treatment for clients who wish to change their orientation, as conversion therapy can work to reduce behaviors but has been shown not to be successful in changing orientation (Cramer et al., 2008). Indeed, even offering or supporting the idea of conversion therapy sends a message to clients that their sexual orientation is problematic and in need of change which is harmful in itself.

Justice is particularly relevant here; what is fair, to whom, and who decides? The false equivalency of upholding fair treatment (that is, to not discriminate) on the basis of sexual orientation and religious beliefs is likely to emerge. It is paramount to consider how the fulcrum of power is being used to affect the person and group most impacted by decisions about conversion therapy and to understand the influence of power on justice. In talking about justice, we need to consider the client at the individual level, the therapist at the individual level, and the relationship between them; however, we cannot stop there as we must consider the larger sociocultural context—which again includes heteronormativity—to decide on what is fair. From a relational ethics frame, the client—particularly a client from an oppressed/marginalized group—lacks the greatest amount of power in the system, according to the role occupied in the therapeutic endeavor (that of client), as well as the status ascribed to them based on identity (LGBTQ), and also for the issue presenting itself for therapeutic consideration—wanting to change one's sexual orientation. It is necessarily harmful to impose one's belief that a client *should* change their sexual orientation based solely on the therapist's religious belief, since there is no legitimate scientific or professional argument otherwise. Further, to actively erase the relevance of the practitioner's own religious beliefs as a factor and hide behind the argument of the autonomy of the client is a subversion of ethics which can lead to therapists upholding their own religious/political beliefs at the expense of clients. Without a shift to relationality and concomitant attention to the dynamics of power, current ethical codes are likely to justify such decisions rather than mitigate them.

There is power in naming the treatment and in defining what is problematic, power associated with one's position in the therapeutic system, power associated with one's identity and the groups to which they belong, and power in being able to deny that one's power impacts others. First, the name *conversion* therapy, otherwise known as *reparative* therapy, has at its roots the view that homosexuality is pathological and that those who identify as such ought to be "converted" or "repaired." The name was developed by professionals, people in positions of power, to remedy the disorder of homosexuality (Blakemore, 2019). That is, professionals who persist in using this language are perpetuating a heterosexist view of sexuality in offering conversion therapy to clients. Moreover, although the DSM no longer categorizes homosexuality as a disorder, the language of conversion therapy continues to live on in the dominant discourse, as its debate and resultant shifts in law keep this inflammatory and discriminatory language and practice in use, both in the professional realm and in the lay realm.

Therapists have the ethical responsibility to appropriately use their power. They can do so by informing clients about the research that has been done on conversion therapy, which shows a lack of efficacy (Ranade & Chakravarty, 2016). Being transparent with clients about how the therapist comes to make decisions about what is helpful or not is a hallmark of ethical and good therapy. Therapists can also acknowledge the power they have as part of their therapist role in making decisions; this may or may not include heterosexual privilege they have, depending on

their identity (Murphy & Hecker, 2017). Likewise, therapists can talk with parents about their ethical responsibility to protect vulnerable clients, particularly youth who are questioning their identity (Murphy & Hecker, 2020).

It is therefore imperative that the therapist engage in self-reflection about their own values: to put aside their own personal beliefs and preferences and to work with clients in a way that is just and not harmful. Justice and nonmaleficence, in this case, may need to be prioritized, given the knowledge that the Code of Ethics is inherently—and harmfully—heteronormative. It is incumbent upon the practitioner to engage in ongoing learning about statistics, research studies, and outcomes of the treatment they are being asked to consider providing, and to engage in the often-times difficult work of coming to understand and accept evidence that is contrary to one's accepted beliefs and values.

In making a decision about providing conversion therapy to a client who requests it, practitioners who routinely consider larger sociocultural political themes and the power those themes provide to themselves, clients, and the therapeutic endeavor will make a decision that is in the best interests of the client as well as for society at large (Alvelo et al., 2016). How the decision is imparted to the client is reflective of the care and compassion of the clinician. It may be quite therapeutic to explore the clients' desire for conversion therapy, to include their personal values, wants, needs, desires, and experiences, as well as those of their family—while considering the dominant discourses evident at larger levels (Dessel et al., 2017). This is not conversion therapy, which by definition is meant to *intentionally alter* sexual orientation and always in the direction of heterosexuality. Those clinicians who still insist that conversion therapy is ethical are likely to appear to rest their concern on the client's expressed need, while failing to acknowledge (a) that science suggests that one cannot artificially alter identity; and (b) the imposition of the therapist's values onto the client. Yet, the harm is not only in imposing the therapists' values onto the client; it is the therapist's failure to acknowledge how they benefit personally and as a member of a larger group in upholding the treatment (conversion therapy).

No matter how aware a therapist is, and how they may decide to use their power to challenge heterosexism in their practices, state laws are being written to try to legislate or empower those who invoke ethics to counter heterosexist practices. Conscience clauses are being brought by state legislatures that allow professionals—including therapists—to opt out of treating LGBTQ clients due to religious beliefs. These conscience clauses conflict with professions' codes of ethics (Rose et al., 2019). In the educational realm, courts to date have ruled in favor of programs being able to determine their own curriculum. Rose et al. (2019) provide recommendations for therapists in supporting their work with LGBTQ clients.

Training Issues and Gatekeeping

It is a learned skill to become self-reflective. Prospective students interested in the field may not be aware of the ethical issues that they will encounter; therefore, it is an ethical responsibility of training programs to provide a gatekeeping role and only admit students who are academically and personally prepared to pursue graduate study that eventually allows them to work with clients—who can be considered a wholly vulnerable population. Within the population of clients are further marginalized groups; here, I focus on LGBTQ clients. Training programs must actively train students to be attuned to and be able to effectively work with LGBTQ clients. Part of the provision of affirmative therapy—which programs need to educate students about—involves challenging heteronormativity; to fail to do so is to engage in discriminatory treatment of this vulnerable group based on sexual orientation.

Aside from the AAMFT Code of Ethics, Standard 1.1, training programs are left without further guidance as to how to ensure that clients are receiving nondiscriminatory treatment. What may seem like a straightforward commitment to inclusion can be—and has been—challenged

by students who claim that having to work with a LGBTQ client violates their religious beliefs (see *Ward v Wilbanks*; Kaplan, 2014). That case has impacted the field in terms of what could be considered best practices in ensuring that clients continue to receive nondiscriminatory treatment while recognizing students' religious beliefs.

There are several steps that training programs can take to ensure the autonomy of prospective students, who have the right to know the expectations of the field as well as those of the training programs to which they apply. Training programs can develop a diversity/inclusion statement that articulates the program's values around nondiscrimination, and the expectation that students will learn to work with all clients who present for therapy, within the scope of practice/competence. This means making a clear statement that students can and will be likely to work with members of the LGBTQ population during their time in the program. The diversity/inclusion statement can clearly say that if a prospective student cannot abide by the program's values, then they can seek training elsewhere. All programs have values that are contained within their training philosophy—whether they are stated or not. Providing a values statement allows prospective students the autonomy of deciding which school to attend.

A well-developed diversity/inclusion statement can be posted on the program's website and included in all advertising/marketing materials, so that again, prospective students can be well-informed about the type of training they will receive. These statements can implicitly or explicitly challenge heteronormativity as well as sexism, racism, classism, and other "isms," and can communicate a message to all that the program takes these issues seriously. Training programs can present their diversity statement to all prospective students; applicants can be asked to write about their response to the diversity statement in their autobiographical statement. Prospective students can also be asked to respond to the diversity statement during group and individual interviews with faculty. An early and repeated emphasis on diversity can impress upon the student that the program values inclusivity and nondiscrimination.

Programs can develop competencies around providing nondiscriminatory care to LGBTQ clients. It is also strongly recommended that programs have clear remediation policies and procedures in place in the event that a student refuses to treat an LGBTQ client, or refuses to address issues related to sexuality while providing services to clients (Burkholder et al., 2014; Dugger & Francis, 2014). Nguyen et al. (2016) suggest that programs require students sign an agreement to treat LGBTQ clients.

Yet, what a diversity statement does not address is the troubling possibility of students who do not agree with nondiscriminatory values being able to find a training program that *does* discriminate. This can and does happen with alarming frequency. The AAMFT Code of Ethics, once again, provides no guidance for training programs. There are exceptions to nondiscrimination written into the COAMFTE Accreditation Standards (2020), which states:

> The program does not discriminate on the basis of race, age, gender, ethnicity, sexual orientation, relationship status, gender identity, socioeconomic status, disability, health status, religious or spiritual belief, religious or spiritual affiliation or national origin in any of its activities or policies relating to students, faculty, including instructors, supervisors, other relevant educators and professional staff.
>
> Programs with a religious mission, purpose or affiliation with policies that are directly related to their religious mission, purpose or affiliation that are in conflict with the aforementioned COAMFTE diversity definition, must have published policies that are accessible, publicly available and disclosed to all individuals seeking to have an affiliation with the program. In all instances, the program must comply with applicable state, provincial and federal nondiscrimination laws and regulations.
>
> *(p. 10)*

The challenge presented by the accreditation standards is the explicit statement that programs must comply with laws and regulations; however, left out of the accreditation standards are those programs that themselves need to adhere to the AAMFT Code of Ethics. Presumably, faculty, supervisors, instructors, and other educators would cite the AAMFT Code of Ethics when upholding Standard 1.1 in relation to treating clients.

Other professions have revised their Codes of Ethics in response to legal challenges. Pope (2014) describes how the American Counseling Association has made specific changes to their code of ethics to address specifics about referring out, addressing larger social and historical prejudices, and the need to use scientific bases for treatment modalities to counter the use of conversion therapies. Still, the Council for Accreditation of Counseling and Related Educational Programs (CACREP) accredits programs that disallow diverse sexual orientations (Smith & Okech, 2016).

When a therapeutic or training situation results in controversy, a false equivalency of nondiscrimination regarding sexual orientation and religious beliefs is often invoked where both parties are painted as equally aggrieved and deserving of special protection. This can be revealed as falsely equivalent for several reasons. First, when considering the most vulnerable group in the therapeutic endeavor, it is apparent that clients—by virtue of seeking help for particular mental health or relational concerns—are most vulnerable. The rights of the client to be treated outweigh the right of a therapist to practice therapy according to their religious beliefs—it is a false equivalency to argue that both concerns are on the same level, and that both the client's concerns and the therapist's concerns are equally addressed in the Code of Ethics. When the client's sexual orientation is factored in, they are additionally vulnerable because of the aforementioned stress (minority stress), they experience in being cast as outsiders, or at least outside the norm, despite progress made in federal law regarding same-sex marriage. There is an additional false equivalency regarding who the Code of Ethics is purported to be written for: if the Code is for clients *and* prospective students, then clients are still the most vulnerable group, as they have the least amount of power on multiple levels and on several relational considerations. The Code of Ethics does not adequately address power dynamics, including who has the ability to decide the health and normalcy of another's actions or beliefs. Put another way: according to the Code of Ethics, are prospective students, students, therapists, or supervisors entitled to be able to practice in a discriminatory manner? Therapists have the right to their religious beliefs, although that right does not extend to the right to practice a particular profession. As Pope (2014, p. 92) states, "Further, there is no 'right' found in any government document to date—court decision, rule, or regulation—to be a counselor, or to be admitted into an educational institution, or to graduate from such an institution." If the profession and its values are incompatible with a person's religious beliefs, then that person/professional/student, because of the power they will hold in their future position, should not be able to practice at the expense of the more vulnerable. That is, "freedom of religion and speech does not mean freedom to discriminate" (Bidell, 2016, p. 74). One's religious beliefs do not equal the ability to work any job. It is the responsibility of all training programs to uphold the ethical principle of justice through nondiscrimination.

It has been mentioned previously that traditional ethical decision-making models rest on the assumption that the practitioner will detect that an ethical dilemma is present, or that an ethical decision needs to be made. Instead, to engage in ethical *being*, we need to be thinking about how what we do has an ethical impact moment-to-moment on others as well as on self. Given that we are all raised in a heteronormative, patriarchal society, we need to continually challenge others and ourselves to un-learn harmful beliefs about marginalized groups, including the LGBTQ community. Training programs need to be at the front lines of engaging in conversation—this challenging of self and other—around heterosexist beliefs and their associated sexist, racist, and "othering" beliefs (Greene, 2007). This can be fostered in part by intentionally recruiting

LGBTQ faculty and students as a means to deepen the authenticity and sophistication of these conversations as preparation for ethical practice with LGBTQ clients.

Part of the gatekeeping role must further involve examining whether prospective students can indeed engage in self-reflection and continuous learning in a manner that demonstrates openness to others—or at least nondiscrimination at a minimum. Prospective students—and even professionals who have been in the field for any number of years—need to demonstrate openness to criticism, critique, accountability, and responsibility. This is not a neutral statement; it is a statement of values that are consistent with appropriate care for LGBTQ clients, and for all clients.

Referring Clients Out

There has been much writing about the ethics of referring clients out. Indeed, part of the dilemma for the training program involved in the *Ward v Wilbanks* case was the student therapist's wish to refer a client out, due to her unwillingness to work with a gay client (Kaplan, 2014). The ethical justification of this stance rests partly in the assumption that working with a therapist with hostile LGBTQ religious beliefs could harm LGBTQ clients and therefore is too great a risk to ask the client to endure. There are several problematic parts to that rationale, all of which are rooted in heteronormativity.

First, referring an LGBTQ client out means that the therapist (who makes the decision) learns that the client is LGBTQ at some point; however, the client's identity may or may not be readily apparent at the start of therapy (Hecker & Murphy, 2015). Many clients rightfully protect their identity until they establish that the therapist provides a safe environment for therapy to occur, so it may be many sessions into the therapy before the client reveals themselves to be LGBTQ—at which point the therapeutic relationship has been presumably developed. The discriminatory and unethical therapist then decides—upon learning of the client's identity—that they must refer out due to their own religious beliefs (Balkin et al., 2014). There is harm to the client in referring out, particularly after a relationship has been developed, because the referral is about *who the client is as a person*. This is different from other situations in which a referral is made, whether because the presenting problem (i.e. a clinical issue) is outside the therapist's scope of competence or outside the therapist's scope of practice. At these points, it can be helpful to substitute another group for the group under discussion here. Would it be ethical to refer out a client who is Black just because they are Black? Or to refer out a person who is Catholic because they are Catholic? The field does not routinely discuss these possibilities because they are not considered legitimate possibilities and are simply considered unethical. The same must be said for clients who identify as LGBTQ.

Some clients hide their identity precisely *because* of heteronormativity routinely experienced from therapists (Bowers et al., 2010) and simply navigating life. In the therapeutic endeavor, where it is hoped that clients can feel comfortable revealing themselves and otherwise becoming vulnerable, it is imperative that the therapist does not deny clients services because of their identity. This is harmful to that particular client; it is harmful to the therapeutic relationship between that client and the therapist and any other therapeutic relationship that client potentially enters into; it is harmful to the client's social network who may hear about their negative experience with this therapy provider; it is harmful to the profession of family therapy (and other mental health professions) because we all will be looked at with suspicion, rightfully so; and it is further harmful to the LGBTQ community, who as a whole have learned to be cautious in seeking therapy lest they encounter discriminatory therapists. Indeed, McGeorge et al. (2016) found that many negative beliefs about LGB clients predicted common therapists' beliefs that it was ethical to refer out, thus confirming the discriminatory bias some LGBTQ clients fear.

Even if therapists were able to know ahead of time that a client identifies as LGBTQ, it is still discriminatory to refer the client out. Clients have a reasonable expectation upon seeking services that they will be treated with dignity and respect, and that clinicians will be able to treat them and—at a minimum—they will not be refused services because of their identity. Likewise, LGBTQ people in relationships have a right to expect relational therapists—MFTs—to be able to work with them in a relational and systemic manner. Therapists are discriminating if they decide they can work with an LGBTQ individual but not work with them and their relationships, simply on the basis of their identity.

Another argument used to justify referring out relates to a therapist's scope of competence. AAMFT Code of Ethics (2015) Standard 3.10, Scope of Competence, reads "Marriage and family therapists do not diagnose, treat, or advise on problems outside the recognized boundaries of their competencies." This standard has been used as justification for therapists, or therapists-in-training, to refer an LGBTQ person out. The conundrum this presents is how one is to work on developing competence if one refuses to work with a particular client. However, the use of scope of competence to refuse to treat LGBTQ clients seems only to apply to LGBTQ clients; this conundrum is not raised in relation to other identities, and if it is, it is viewed as more readily discriminatory. For example, imagine a therapist or therapist-in-training refusing to treat a visually impaired client, or a client who identifies as Latinx. In the latter cases, it would be expected that the therapist learn about the culture of these clients and provide services to them. Moreover, in a training context, we do a disservice to students learning to be therapists if we do not challenge them to work with clients who are different from themselves (Bang et al., 2019). As part of providing affirmative therapy, students can work to let go of the gender binary that constrains clients and relationships of healthy options (Campbell & Arkles, 2017).

Affirming Trans Identities

Oftentimes, an ethical dilemma will seemingly present itself when a (usually minor-aged) trans client presents for therapy with family members distressed about the youth's identity. Especially if the family holds religious values that indicate non-acceptance of the youth's identity, or families express concern about social pressures exerted from other family members, friends, or social groups in response to their trans youth's identity, therapists may sense a potential ethical dilemma—rooted in heteronormativity—which is that they must walk a line between respecting family beliefs and traditions and supporting the trans client in their identity. However, this is a dilemma only insofar as the clinician accepts the heteronormative perspective of the family, which places the youth at risk for judgment and non-acceptance, and the associated risk of harm to self that may result. In essence, an affirmative, ethical approach sees this as a clinical issue rather than an ethical issue in that the clinical work needs to be centered on helping the family accept and support the trans client's identity; to do otherwise is to inflict serious harm to the client who is the most vulnerable person in the system.

Similarly, an LGBTQ client may present—at some point in therapy—a concern about identity management, or whether (and how much) to reveal one's identity to various people in their lives, including partners, parents, siblings, children, friends, and employers, to name a few. Here, the ethical dilemma may lie in the therapist providing support to the client in talking through their decisions to reveal parts of their identity to others, at the risk of upholding shame that may accompany one's view of self, such that a client does not want to risk revealing themselves to others. Yet again, the ethical dilemma turns into a clinical concern in empowering clients to decide for themselves (that is, exert autonomy) what is best for them in certain situations, while also talking with them about the larger sociocultural political themes that impact their decision-making, and the very real consequences they may experience in coming out to others. Therapists may need to support clients' decisions to keep their identity confidential (Hecker & Murphy, 2018).

A Way Forward

Embracing Relational Ethics

Shifting from ethics that centers the individual to relational ethics would be a paradigm shift that offers more possibilities of inclusive, accepting, and supportive therapeutic work. The effects would be both large and small: decision-making would not be seen as the pinnacle of ethics; instead, we would be engaged in relating with each other, making ongoing consideration of self *and* other the primary vehicle for ethical relations. The Code of Ethics would take a clear stand in favor of science and research while articulating the importance power vested as part of role and identity for all involved in the therapeutic endeavor. A clear stand against heteronormativity would be state in the Preamble as well as part of a standard in the Code of Ethics, along with other harmful systems that intersect with heteronormativity, such as patriarchy and white supremacy. Codes of Ethics would call for consideration of relational, contextual, and community factors as part of ethical relating expected of professional members.

The Ethical Imperative for Self-of-Therapist Work

It can be tempting to blame others as sources of heteronormativity; certainly, our professions' Code of Ethics and decision-making models contribute to upholding heterosexist norms. However, there is a danger in relying too much on the other, a danger in upholding a binary that suggests that we are not responsible nor complicit in upholding heteronormativity. This is precisely why self-of-therapist work is *crucial* to challenging heteronormativity. We all play a part in upholding or challenging the status quo.

There is an ethical imperative for self-of-therapist work so that therapists can be of service to others (Balick, 2009). First, we need to be continually challenging the heteronormative messages we all receive as part of navigating U.S. culture. This is true no matter our sexual or gender identities. Research shows that we are most able to empathize with others when we interact with people; we need to immerse ourselves in the varied ways people live and relate; that may mean reading works of LGBTQ peoples, developing friendships and professional relationships with LGBTQ people, participating in professional trainings, etc. Kassel and Martino-Harms (2014) suggest that therapists engage in self-reflection, dialogue, and academic engagement; there is an imperative to internalize the ethics of the profession and to allow ourselves to be transformed by them when that is what is required. Leland and Stockwell (2019) highlight the need for self-assessment; this is part of ongoing learning that is crucial, and none of us are ever done learning. They offer a self-assessment tool for affirming practices working with transgender and gender-non-conforming clients (TGNC; Leland & Stockwell, 2019). Awareness is an ethical start; yet, developing competence is critical. MFTs can look to other fields for more specific guidance on developing competences in working with LGB clients. The American Psychological Association has outlined competencies working with LGB clients (Lyons et al., 2010).

These suggestions capture the heart of relational ethics—the connection between self and other, the consideration of larger community voices and needs, which can only take place via dialogue and engagement with other. The call is to be open to others' views, to consider needs beyond one's own, and to actively participate in challenging harmful discourses that render particular groups most vulnerable.

Envisioning the Future

Many of these ethical quandaries would not be considered ethical quandaries if the field of family therapy was not rooted in heterosexism and heteronormativity. Conversion therapy would not be even a consideration—it would be seen and exposed as the illegitimate, unethical, inappropriate treatment that it is. Therapists would not rationalize their lack of suitability as

therapists for LGBTQ clients. The idea of referring LGBTQ clients out as a result would become moot; this just would not happen in the field as those therapists would not be therapists. There would be no ethical dilemmas in training programs as far as needing to express a particular value of inclusion for LGBTQ people and their concerns. There would be no question about accepting anyone's gender or sexual identities.

Indeed, there would be no difference between affirmative therapy and therapy provided to any and all clients.

References

Alvelo, P. J., Maguire, N., & Knauss, L. K. (2016). Sex, gender, and psychological assessment: Integrating principle and feminist ethics. In V. M. Brabender & J. L. Mihura (Eds.), *Handbook of gender and sexuality in psychological assessment* (pp. 627–654). Routledge.

American Association for Marriage and Family Therapy. (2015). *Code of ethics.* https://www.aamft.org/Legal_Ethics/Code_of_Ethics.aspx

Balick, A. (2009). Relational ethics beyond the sex and gender binary: An integrative relational approach. In L. Gabriel & R. Casemore (Eds.), *Relational ethics in practice: Narratives from counselling and psychotherapy* (pp. 32–43). Routledge.

Balkin, R. S., Watts, R. E., & Ali, S. R. (2014). A conversation about the intersection of faith, sexual orientation, and gender: Jewish, Christian, and Muslim perspectives. *Journal of Counseling & Development, 92*(2), 187–193. https://doi.org/10.1002/j.1556-6676.2014.00147.x

Bang, N. M., Filmore, J. M., & Lane, E. (2019). Prepared and not prepared: Which culture decides? Incident and responses. In T. A. A. Portman, C. Wood, & H. J. Fye (Eds.), *Critical incidents in school counseling* (3rd ed., pp. 113–120). American Counseling Association.

Bidell, M. P. (2016). Mind our professional gaps: Competent lesbian, gay, bisexual, and transgender mental health services. *Counselling Psychology Review, 31*(1), 67–76.

Blakemore, E. (2019, June 28). *Gay conversion therapy's disturbing 19th-century origins.* https://www.history.com/news/gay-conversion-therapy-origins-19th-century

Bowers, R., Minichiello, V., & Plummer, D. (2010). Religious attitudes, homophobia, and professional counseling. *Journal of LGBT Issues in Counseling, 4*(2), 70–91. https://doi.org/10.1080/15538605.2010.481961

Burkholder, D., Hall, S. F., & Burkholder, J. (2014). Ward v Wilbanks: Counselor educators respond. *Counselor Education and Supervision, 53*(4), 267–283. https://doi.org/10.1002/j.1556-6978.2014.00062.x

Campbell, L. F., & Arkles, G. (2017). Ethical and legal concerns for mental health professionals. In A. Singh & lore m. dickey (Eds.), *Affirmative counseling and psychological practice with transgender and gender nonconforming clients* (pp. 95–118). American Psychological Association. https://doi.org/10.1037/14957-005

Commission on Accreditation for Marriage and Family Therapy Education. (2020). *Accreditation standards: Graduate & post-graduate marriage and family therapy training programs* (Version 12.5). https://coamfte.org/documents/COAMFTE/Accreditation%20Resources/COAMFTE%20Standards%20Version%2012.5%20-%20Published%20December%202020.pdf

Cramer, R. J., Golom, F. D., LoPresto, C. T., & Kirkley, S. M. (2008). Weighing the evidence: Empirical assessment and ethical implications of conversion therapy. *Ethics & Behavior, 18*(1), 93–114. https://doi.org/10.1080/10508420701713014

Dessel, A. B., Jacobsen, J., Levy, D. L., McCarty-Caplan, D., Lewis, T. O., & Kaplan, L. E. (2017). LGBTQ topics and Christianity in social work: Tackling the tough questions. *Social Work & Christianity, 44*(1–2), 11–30.

Dopp, A. R. (2013). Treatment of sexual minority youth: Ethical considerations for professionals in psychology. *Ethics & Behavior, 23*(1), 16–30. https://doi.org/10.1080/10508422.2012.728474

Dugger, S. M., & Francis, P. C. (2014). Surviving a lawsuit against a counseling program: Lessons learned from Ward v Wilbanks. *Journal of Counseling & Development, 92*(2), 135–141. https://doi.org/10.1002/j.1556-6676.2014.00139.x

Gamboni, C., Gutierrez, D., & Morgan-Sowada, H. (2018). Prohibiting versus discouraging: Exploring mental health organizations varied stances on sexual orientation change efforts (SOCE). *American Journal of Family Therapy, 46*(1), 96–105. https://doi.org/10.1080/01926187.2018.1437572

Green, R. -J. (2003). When therapists do not want their clients to be homosexual: A response to Rosik's article. *Journal of Marital and Family Therapy, 29*(1), 29–38. https://doi.org/10.1111/j.1752-0606.2003.tb00380.x

Greene, B. (2007). Delivering ethical psychological services to lesbian, gay, and bisexual clients. In K. J. Bieschke, R. M. Perez, & K. A. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, bisexual, and transgender clients* (2nd ed., pp. 181–199). American Psychological Association. https://doi.org/10.1037/11482-007

Hancock, K. A. (2014). Student beliefs, multiculturalism, and client welfare. *Psychology of Sexual Orientation and Gender Diversity, 1*(1), 4–9. https://doi.org/10.1037/sgd0000021

Haslebo, G., & Haslebo, M. L. (2012). *Practicing relational ethics in organizations.* Taos Institute Publications.

Hecker, L. L., & Murphy, M. J. (2015). Contemporary and emerging ethical issues in family therapy. *Australian and New Zealand Journal of Family Therapy, 36*(4), 467–479. https://doi.org/10.1002/anzf.1121

Hecker, L. L., & Murphy, M. J. (2018). Ethical issues in couple and family therapy. In M. M. Leach & E. R. Welfel (Eds.), *The Cambridge handbook of applied psychological ethics* (pp. 239–262). Cambridge University Press. https://doi.org/10.1017/9781316417287.013

Kaplan, D. M. (2014). Ethical implications of a critical legal case for the counseling profession: Ward v Wilbanks. *Journal of Counseling & Development, 92*(2), 142–146. https://doi.org/10.1002/j.1556-6676.2014.00140.x

Kassel, P., & Martino-Harms, J. (2014). Professional competencies and training related to LGB populations: Reactions to Hancock's (2014) paper. *Psychology of Sexual Orientation and Gender Diversity, 1*(2), 109–111. https://doi.org/10.1037/sgd0000028

Leland, W., & Stockwell, A. (2019). A self-assessment tool for cultivating affirming practices with transgender and gender-nonconforming (TGNC) clients, supervisees, students, and colleagues. *Behavior Analysis in Practice, 12*(4), 816–825. https://doi.org/10.1007/s40617-019-00375-0

Lyons, H. Z., Bieschke, K. J., Dendy, A. K., Worthington, R. L., & Georgemiller, R. (2010). Psychologists' competence to treat lesbian, gay and bisexual clients: State of the field and strategies for improvement. *Professional Psychology: Research and Practice, 41*(5), 424–434. https://doi.org/10.1037/a0021121

McGeorge, C. R., Carlson, T. S., & Farrell, M. (2016). To refer or not to refer: Exploring family therapists' beliefs and practices related to the referral of lesbian, gay, and bisexual clients. *Journal of Marital and Family Therapy, 42*(3), 466–480. https://doi.org/10.1111/jmft.12148

McGeorge, C. R., Carlson, T. S., & Toomey, R. B. (2015). An exploration of family therapists' beliefs about the ethics of conversion therapy: The influence of negative beliefs and clinical competence with lesbian, gay, and bisexual clients. *Journal of Marital and Family Therapy, 41*(1), 42–56. https://doi.org/10.1111/jmft.12040

Murphy, M. J., & Hecker, L. (2017). Power, privilege, and ethics in couple and family therapy. In M. J. Murphy & L. Hecker (Eds.), *Ethics and professional issues in couple and family therapy* (2nd ed., pp. 99–119). Routledge. https://doi.org/10.4324/9781315628240

Murphy, M. J., & Hecker, L. L. (2020). Ethical and legal issues unique to systemic family therapy. In K. S. Wampler, R. B. Miller, & R. B. Seedall (Vol. Eds.), *The handbook of systemic family therapy: The profession of systemic family therapy* (pp. 531–554). Wiley. https://doi.org/10.1002/9781119438519.ch23

Nguyen, H. N., Grafsky, E. L., & Piercy, F. P. (2016). MFT program policies on referral of LGBT clients. *Contemporary Family Therapy, 38*(3), 307–317. https://doi.org/10.1007/s10591-016-9389-3

Pope, M. (2014). Who controls the training of new mental health professionals? *Psychology of Sexual Orientation and Gender Diversity, 1*(2), 90–92. https://doi.org/10.1037/sgd0000025

Ranade, K., & Chakravarty, S. (2016). 'Coming out' of the comfort zone: Challenging heteronormativity through affirmative counselling practice with lesbian and gay clients. In P. Bhola & A. Raguram (Eds.), *Ethical issues in counselling and psychotherapy practice: Walking the line* (pp. 141–154). Springer Science + Business Media. https://doi.org/10.1007/978-981-10-1808-4

Rose, J. S., Kocet, M. M., Thompson, I. A., Flores, M., McKinney, R., & Suprina, J. S. (2019). Association for Lesbian, Gay, Bisexual, and Transgender Issues in Counseling's best practices in addressing conscience clause legislation in counselor education and supervision. *Journal of LGBT Issues in Counseling, 13*(1), 2–27. https://doi.org/10.1080/15538605.2019.1565800

Rosik, C. H. (2003). Motivational, ethical, and epistemological foundations in the treatment of unwanted homoerotic attraction. *Journal of Marital and Family Therapy, 29*(1), 13–28. https://doi.org/10.1111/j.1752-0606.2003.tb00379.x

Shaw, E. (2011). Relational ethics and moral imagination in contemporary systemic practice. *Australian and New Zealand Journal of Family Therapy, 32*(1), 1–14. https://doi.org/10.1375/anft.32.1.1

Smith, L. C., & Okech, J. E. A. (2016). Ethical issues raised by CACREP accreditation of programs within institutions that disaffirm or disallow diverse sexual orientations. *Journal of Counseling & Development, 94*(3), 252–264. https://doi.org/10.1002/jcad.12082

Taylor & Francis
Taylor & Francis Group
http://taylorandfrancis.com

Section II
Working with Couples

Taylor & Francis
Taylor & Francis Group
http://taylorandfrancis.com

4
We Cannot Change What We Cannot Name for Ourselves

Integrating Attachment Theory into Couple Therapy with Gay Men

ROBERT ALLAN

Miguel and Atticus met 14 years ago at a club during Pride celebrations. The weather that night, the club, and the music were all hot which matched their first impressions of each other. The immediate physical attraction turned to more in the weeks after first meeting as they discovered their shared values were the foundation they were looking for to start a relationship. They started living together a year after they met and got married shortly after it became legal in 2015.

Miguel identifies as Mexican-American, born and brought up in the United Sates in a working-class neighborhood that was racially diverse and had various migration stories woven throughout the area. When he lived at home, he went to Catholic Church with his family; while valuing the connections with people in the church, he could not reconcile his involvement with the Church after coming out. After an initial struggle when Miguel came out to them, his family reflected the values Miguel was taught about family growing up and he experienced their dedication, commitment, and loyalty to family which now includes his husband. When family gather, they are both expected to attend and they are involved in family relationship struggles even when they sometimes prefer not to be.

Atticus grew up in the south in a small town and in a family that identifies as white, conservative, and Baptist. His family taught him to be direct in his communication and use humor to cope. His father was head of the household and the sole wage earner, and his mother managed the household. While told to treat everyone equally, it was clear to Atticus that edict did not apply to people who do not identify as cisgender or heterosexual. While expected to complete high school then find a job, work hard, and support a family, Atticus pursued college and found a way out by completing a master's degree and becoming a health care professional. As soon as he could, he moved to a mid-sized city with a gay community to start his career. His family rejected him when he told them he is gay and have little contact with him now, sticking to brief communications during holidays and birthdays.

Gay Men Fight for Relationships

Gay men come into their relationships with a lifetime of messages about what is wrong with being gay and little to no information, experience, or modeling about loving and being loved by another gay man. That so many gay men are still compelled to find meaningful relationships in their lives is both a testament to their resilience and their strength, and points to the importance of creating meaningful relationships in our lives. As Johnson (2019a) writes, "it is especially

DOI: 10.4324/9780429274626-7

important to note the impact of secure attachment on emotion regulation, social adjustment, and mental health" (pp. 10–11). The drive to form significant bonds with other people is, in part, about survival, and in the face of so many messages questioning whether we should survive, gay men have found ways to celebrate our relationships.

As Tunnell (2012) noted, the social justice advancements made with the inclusion of gay men in institutions like marriage in the United States (U.S.) do not eliminate the effects of "internalized homophobia and male gender-role socialization that wreak havoc on achieving intimate connections between gay men" (p. 25). Further, with social advancements come backlash (Flores, 2019). We are in the midst of a series of political movements designed to create policies and laws that either limit recognition or legislate exclusion of people who do not identify as cisgender or heterosexual.

The Movement Advancement Project is an independent, non-profit think tank that provides rigorous research, insight, and communications about legislation and policies related to lesbian women, gay men, bisexual, and trans persons (LGBTQ). Their website (http://www.lgbtmap.org) contains "equality maps" which provide a clear visual of the degree to which gender or sexual minorities are supported by local, state, and federal policies and legislation. Looking at a map of the U.S. provides a clear picture of how much or how little we are supported or protected in the U.S.. Most glaring is the lack of explicit inclusion of sexual orientation in the federal Civil Rights Act of 1964, which prohibits "discrimination based on race, color, religion, sex, or national origin in public places, employment and education" (Ballotpedia, n.d.). Although the U.S. was the 17th country to legalize same-sex marriage, it lags behind several other countries implementing federal protection for employment, housing, and services. In fact, efforts are being made to create religious exemptions which provide a license to discriminate against LGBTQ people (Thoreson, 2018).

> Initially, they were somewhat isolated from Miguel's family as he did not share information about who he was dating and Atticus had no contact with his family at this point. They primarily socialized with gay friends and people who were very supportive of their relationship. Issues of race emerged early in the relationship as Atticus would hear and ignore negative comments about Miguel, leaving Miguel uncertain if Atticus understood what it meant to be developing a relationship with a Mexican-American man. They would have brief discussions with repeated assurances by Atticus of how much he cared for Miguel and how much he wanted to know more about his experiences and how important it was for him to treat everybody the same.

Attachment Theory and Gay Men

Attachment theory provides a means to understand and explore gay male relationships. Researchers know, for example, that securely attached adults are able to respond positively to others by exhibiting strong conflict resolution and communication (Campbell et al., 2005), turning to others when in distress (Kobak & Sceery, 1988), being more able to self-disclose because they are comfortable with intimacy (Mikulincer & Nachshon, 1991) and reporting greater self-esteem (Feeney & Noller, 1996). In the context of adult romantic relationships, those with secure attachment are generally comfortable with being close and interdependent with their partner. In contrast, avoidantly attached adults are less comfortable with closeness and interdependence; those who are anxious-ambivalently attached fear losing their partner, need to be closer to their partner, and experience frustration with not being close enough.

As Mohr (2008) noted, comparatively little work on the application of attachment theory has been applied to the study of gay male couples. To a large extent, this lack of work and interest is a consequence of systemic heterosexism, which at best erases gay couples from the popular and

scholarly imagination, and at worst actively threatens the validity of gay relationships. Indeed, despite stereotypes to the contrary, gay men are interested in, and form, long-term romantic partnerships. Data from a range of sources suggests that anywhere between 30% and 60% of gay men consistently report being involved in a committed romantic relationship (Black et al., 2000; Elizur & Mintzer, 2003; Herek et al., 2010; Peplau & Fingerhut, 2007). Although a large number of gay men report being in a romantic partnership, discrimination makes it challenging to assess the actual prevalence of gay relationships.

There is a growing body of research that explores gay men's experience of bonding. In one review of the adult attachment research as it pertains to gay men (Allan & Westhaver, 2017), the following four themes were identified:

1. Similarities with heterosexual couples.
2. The impact of heterosexism, homophobia, and coming out.
3. Differences based on experiences with homophobia/heterosexism on attachment dynamics and narratives.
4. Differences in how gay men experience nonmonogamy.

Below is a brief exploration of these four themes.

Similarities

At times, research efforts reflect how gay men experience the same relationships dynamics as heterosexual couples. Mary Ainsworth (1985) wrote that same-sex romantic attachments are likely to function in the same manner as heterosexual attachments. Mohr (2008) noted that gay men report a similar distribution of attachment styles as their heterosexual counterparts. Predictors of relationship satisfaction that are shared between same- and opposite-sex couples include quality of communication, shared interests, intimacy, mutuality, shared power, fidelity, dependability, constructive conflict resolution skills, and humor (Domingue & Mollen, 2009; Kaslow & Robison, 1996; Mackey et al., 2004).

> Two years into their relationship, Atticus and Miguel sat down to discuss HIV testing. They had practiced safer sex throughout their relationship and felt relatively confident about their efforts to keep each other safe in all the ways they knew how, including each other's health. Having enough confidence in their commitment to each other, determining their HIV status felt like the next logical step for their relationship as they discussed exploring sex without condoms with each other. They both agreed to get tested and share their results. While they supported each other through the process, both were also nervous as they felt like some of their past sexual experiences may have exposed them to the virus. On the day they returned to the clinic to get their results, they discussed the possibility that one or both could be HIV+ and vowed to not let it shake their commitment or affect their relationship. Miguel was delighted to learn he was HIV- while Atticus was stunned and terrified to discover that he was HIV+. Miguel held Atticus in a long embrace at the clinic reassuring him of his love and they were going to beat this together.

Although some attachment research points to what experiences are shared between same- and opposite-sex couples, there is also a body of research that emphasizes that attachment dynamics differ for gay men because of gay men's unique experiences with homophobia, heterosexism, and homonegative messaging. There is a substantial focus on early caregiver experiences that impact adult attachment narratives (George et al., 1985) and gay men experience different developmental trajectories than their heterosexual counterparts (Elizur & Mintzer, 2003). The most obvious of these differences are the role of peers in gay men's development and the likely exploration of same-sex attractions later in life than heterosexual male counterparts (Elizur & Mintzer, 2003).

The Impact of Heterosexism, Homophobia, and Coming Out

Coming out is another experience that differs for gay men than their heterosexual counterparts. The coming out process is presumed to activate the attachment system (Mohr, 2008). Attachment strategies can impact the exploratory aspects of identity development for gay men as they begin to name and explore what being gay means. Those insecurely attached may avoid the stress associated with the exploratory aspects of identity development such as attending a gay community event or disclosing their sexual orientation to loved ones. Although the purpose of avoiding these events is to minimize the potential of having to rely on potentially unreliable attachment figures for support, this also deprives these gay men of resources that contribute to resilience in dealing with negative messages. As Mohr and Fassinger (2003) noted, "attachment insecurity may increase susceptibility to fear with regard to the tasks of identity development and curtail the exploration that is often critical in forging a positive LGB identity" (p. 483).

> Life, busy work lives, and their love for each other propelled Miguel and Atticus forward ten years into their relationship. Atticus benefitted from advancements in HIV treatment and his T4 cell count remained high while his viral load was non-detectable. Miguel progressively introduced Atticus into his family who is now accepted as part of their family and expected at all family gatherings. Atticus has mentioned Miguel to his family with whom he now has a cordial and very distant relationship; he has visited them on his own a few times over the years and they have never met Miguel nor shown any interest in meeting him. While they have built a life together, the disagreements between them started to become more escalated. Miguel still struggled to understand why Atticus would ignore the negative comments he heard about him. Atticus had disclosed his HIV status to a few trusted friends and forbade Miguel from telling his family. He did not connect with supports that would allow him an opportunity to explore his HIV status and struggled with Miguel's reassurances when he expressed fear about his life and well-being. Atticus felt like Miguel's comments were perfunctory and that Miguel did not truly understand how scared Atticus was at times living with HIV. After a fight got particularly heated one night, they connected the following day and agreed they needed outside help and would attend couple therapy together.

Attachment Differences Based on Experiences with Homophobia/Heterosexism

A third theme noted in the research is the impact that homophobia, heterosexism, and homonegative messaging have on the way gay men experience close relationships. Research exploring internalized homophobia and attachment strategies found that insecure attachments were most associated with identity confusion, shame, guilt, and internalized homophobia (Sherry, 2007; Wang et al., 2010). Gay men who struggle with internalized homophobia also have negative internalized views of gay relationships and view them as less stable (Mohr, 2008). Feeney and Noller (2004) noted that gay men may cling to or avoid relationships as an adaptive response to social stigma, suggesting that attachment needs are more activated when one experiences daily social stress.

Differences in How Gay Men Experience Nonmonogamy

A final area noted in the adult attachment research as it applies to gay men is the variegated experiences when it comes to monogamy. While research points to attachment avoidance being associated with less relationship commitment and a greater number of sexual experiences for heterosexual men (Feeney, 2008; Gentzler & Kerns, 2004), the research with gay men offers different stories. The research predominantly reported that gay male relationships are the only couple type that report

equal satisfaction, whether the couple is monogamous or not (De la Garza-Mercer et al., 2006; Julien et al., 2003; Kurdek, 1997, 1998; Mohr & Fassinger, 2003; Ramirez & Brown, 2010).

The Clinical Process

> Atticus and Miguel began their search for a couple therapist who had experience with and knowledge of working with gay male couples. Being in the health care sector, Atticus asked a few colleagues for references and they also searched the internet for viable options. It was a frustrating process; so many therapists' websites had generic statements about "all welcome" or an endless list of how they could work with all clinical issues and all people. Although some therapists clearly identified their position and expertise in working with gay men on their websites, they did not all have experience working with couple relationships. Miguel was also concerned about finding a therapist who could relate to his experience as a Mexican-American. He had experienced more stigma in the last couple of years with increased negative media messages about people from Mexico and also had a few experiences of people yelling "go back to your country" at him while they were driving by. They eventually found a therapist and set up an initial appointment.

Connecting with both members of the couple is an important first step in couple therapy, in which the therapist seeks to understand what it is like for both people in the relationship. The therapist working with Miguel and Atticus discussed sociopolitical factors associated with being gay, Mexican-American, and southern, and how they affect relationships as an important part of developing a therapeutic alliance. Day-Vines and colleagues (2007) describe this kind of discussion as "broaching."

Broaching extends throughout therapeutic work and reflects an "ongoing attitude of openness with a genuine commitment by the [therapist] to continually invite the client to explore issues of diversity" (Day-Vines et al., 2007, p. 402). The therapist worked toward what Day-Vines and colleagues call an "infusing" style of broaching where a therapist functions as a celebrant of constructive gay male relationships and engages in an ongoing process of building their personal comfort with love and sexuality between two men. Broaching blends well with the attachment approach to working with gay male couples which normalizes gay bonds and places them in a legitimate context.

Broaching can begin with the therapist acknowledging that a range of sociocultural factors may be affecting the couple relationships, including heterosexism, racism, sexism, and other narratives that impact clients' views of self and of others. Miguel and Atticus' therapist identified as a gay man and reassured them that he was committed to exploring the different experiences of being gay and not assume that his experiences of being gay were the same as Miguel's or Atticus'. The therapist further discussed his race (white), gender (cis-male), social class (working class), religion/spirituality (non-theistic, plural), and invited Miguel and Atticus to name other factors that they considered important to know or additional elements that could impact their relationship. Miguel mentioned that he was raised Catholic and no longer went to church. When prompted, Atticus quietly said, "I don't know, maybe my HIV status?"

The therapist noted this and then explored further with both asking each of them, "what do I need to know about your experience of (identity)?" or "help me understand what it has been like for you to live as a (identity)?" The therapist explored sources of resilience and supports as well as ways that Miguel or Atticus might be constricted in their responses to certain stressors or received messages about themselves or others that would negatively impact their view of self or other as able to receive or provide contact, care, and comfort. The therapist thanked them both and noted that they are welcome to continue to explore these topics with him and he looked forward to getting to know more about them both.

It is important for the therapist to take the lead in broaching, thereby building safety across a variety of issues that may be impacting the couple relationship. Like any therapeutic relationship, there can be ruptures in the alliance which are important to address. Discussing disconnections (Jordan, 2009) that occur in session is critical for the therapeutic relationship and the repair can in fact improve the therapeutic relationship (Safran et al., 2011).

One final note about broaching: some gay men may have adapted the strategy of minimizing recognition and discussion of minority-related stressors. This accommodating approach reduces exposure to the uncomfortable emotions associated with the stressors of oppression. Gay men and/or persons with racialized identities routinely encounter lack of recognition, lack of respect, negative comments, and hostile/threatening interactions or assaults. This accommodating approach is often protective and useful for gay men as they consistently deal with people and systems who are unwilling to recognize the disconnections and oppression they face. However, recognizing and discussing these stressors is a useful long-term mental health strategy. It is imperative that therapists lead ongoing broaching discussions with the knowledge of the impact of minority stressors that gay men face (for more information, see Meyer, 2013) and the reality that many have experienced hate-based discrimination and violence (National Coalition of Anti-Violence Programs, 2017). Therapists can help gay men parse out when short-term accommodation is useful and when a more long-term strategy of recognition and discussion is advisable. Although Miguel enjoyed the broaching discussion, Atticus seemed more reluctant and provided one- or two-word answers to most questions before getting frustrated with the therapist.

A: It feels like we're wasting time here…

Th: Thank you Atticus, I appreciate your letting me know you are frustrated. I want to make sure I get this right; you feel talking about the different ways you both identify is a waste of time?

A: Yes.

Th: Thank you, can we explore that for a bit because I want to be as transparent with you as I can, would that be all right with both of you?

M: Yes, I've been enjoying this discussion, it's making me feel more comfortable.

A: (Sigh) I guess but is this really going to help?

Th: Great question, my goal is to be as helpful as possible for the two of you.

A: So, is this all we're going to talk about in every session?

Th: Probably not, that will be up to the two of you. If I am going to get to know you both well and do the best work I can do, I feel like these are important discussions to have early in our work together to help you both feel comfortable working with me and laying the foundation so that you know you can raise matters related to your different identities with me.

A: OK…ummm…so what now?

Th: Can we just stay with this a little longer?

A & M: Yeah (simultaneously).

Th: Atticus, I am curious, you briefly mentioned that your family does not support your marriage, what is it like for you not to have that part of you acknowledged, recognized, and celebrated by your family?

A: It sucks…

Th: Right, totally sucks, it must hurt, a lot!

A: Yeah, it does.

Th: Well I don't want to replicate that in here with either of you, I don't want you to experience me not seeing, hearing, and validating all of who you are. Does that make sense?

A: I guess it does, I never thought of it that way before, we're not just boxes to tick on an intake form or a diagnosis to make.

Th: Right! I want to make sure that all of you is welcome here and that this is a place you can talk about those things that are hard to talk about because homophobia, racism, sexism, and other ways of silencing people and their experiences prevent us from exploring what those experiences feel like and how they impact us.

On their drive home after the first session, Miguel and Atticus discussed the therapist and how comfortable they felt with him. They both agreed that he was working to balance each of their participation in session which was important for them. Miguel tended to answer most questions first and the therapist would always follow up with Atticus to get his perspective. They were impressed that the therapist wanted to know about their experience in the world beyond the specifics of their relationship though were not quite sure how it would factor into their couple therapy work. They agreed that this was the right therapist to start with and were looking forward to their individual sessions with him.

Following the initial joint session, it is important to meet with each member of the couple individually. Individual meetings are invaluable for getting to know each person in the couple and building an alliance. It is also important for addressing the three As—*abuse, addiction, and affairs*—which cannot be adequately addressed in a joint session nor via an intake form. A variety of information can be gathered during an individual session, including motivation for the therapy work, coming-out stories, experiences of intersectional marginalization and how they are supported through those experiences, attachment injuries, and gathering an attachment history. The latter gathers information about who the person went to for comfort as a child, how they were responded to, when they were most likely to be responded to, how they would seek comfort, and other questions that explore their early life attachment strategy under stress.

During the assessment phase, understanding coming-out stories and experiences of intersectional marginalization from an attachment perspective provides a therapist with a clearer map for how internal working models of self and other were developed. A client can simultaneously tell a story of experiencing safety and security when they went to a parent as a young child when distressed then go on to describe how they were kicked out of the house or sent to conversion therapy or abused and harassed after coming out to their parents. The following questions are examples of exploring a client's developing gay identity and can be integrated into individual sessions. A therapist does not have to ask all the questions; yet, the first few questions will likely open up a much wider discussion:

1. What was your coming out process like?
2. When did you first become aware that you were attracted to someone of the same sex?
3. What were the messages that you received from your family/community about being attracted to someone of the same sex?
4. Was there any person you could talk to about these feelings?
5. What did you do with these feelings if there was not a safe person to talk with about it?
6. Did you ever feel like your life was in danger or under threat as a result of your sexual orientation?

The therapy with Miguel and Atticus continued with them jointly. At their first meeting following the individual sessions, the therapist checked in with them both about the individual session and relayed how much he appreciated their commitment to each other and willingness to continue to work on their relationship with him. The therapist then started to explore their negative interaction cycle (Johnson, 2019b). This cycle corrodes the relationship and the identification of the cycle is "integrated into the awareness of underlying emotions and the couple begin to see how they create the cycle of distress which in turn perpetuates

their anxieties and reactive ways of dealing with these anxieties" (Johnson, 2019b, p. 141). The therapist explores, with the aim to understand, how emotional disconnections impact the couple system. Therapists working with gay men who have had their view of self and other repeatedly violated by homonegativity need to assess the attachment significance of these events, not the content itself. A focus on the attachment significance includes assessing whether they see relationships with other men as safe and framing attachment needs in the context of the stressors they have had and continue to experience. In this case, stressors that include homonegative attitudes intersected for Miguel with racism and xenophobia, and for Atticus his HIV+ status. What follows is a segment from the fourth session with Atticus and Miguel in which the therapist explores their negative interaction cycle; they started to escalate in session trying to explain their view of the cycle:

Th: Can I slow you both down? I can see how important this is for you both and you know how much I want to hear from both of you. Can I start with you Miguel, would that be all right with you Atticus?

A: I guess…

Th: Miguel, you were starting to tell me about a time you came home and told Atticus about an incident that occurred that day when someone yelled at you out of the car, "go back to your country!" along with several other hurtful words. I am so sorry that happened, that is inexcusable!

M: Thank you, I don't know what is going on, I was born here and I hear more of that kind of stuff lately, it makes me angry!

Th: Me too. And you have every right to be angry! Can I ask you a little bit about when you got home that evening and mentioned it to Atticus?

M: Uh huh.

Th: So can you bring me to that moment when you got home, upset, and you see Atticus.

M: I was still upset and looking forward to seeing him, I wanted to share it with him, feel like I could get some support or understanding.

Th: Of course, this is the guy you most want to count on in times like this, he means a lot to you.

M: Yes, but that's not what I got that evening.

Th: Oh? That must have been so hard?

M: It was, I was hurt.

Th: Ok, can we go nice and slow here, help me understand what was going on for you?

M: Sure, I came in the door and started telling him, didn't really say hello, he looked at me blankly and I started to get angry again telling him the story.

Th: You started to get angry, did your voice raise or tone of voice change?

M: Both, he just stood there, didn't move or say a word! No expression on his face!

Th: That must have been so hard, you were upset, angry, keen to see him and as you are telling him about that horrible incident you see him standing there, saying nothing, as if he didn't care?

M: Yes!

The therapist continued to explore their cycle, helping each of them grasp the reactive aspects of their pattern. Miguel would get angry, thinking Atticus truly does not care about him and what a fool he has been to believe in their relationship; he would sometimes call Atticus names and yell at him. Atticus would get overwhelmed, stuck, frozen; he would think to himself that he was stupid for not knowing what to say and think Miguel is overreacting, did Miguel not know how much he cared for him? Eventually, Atticus would shrug his shoulders and stare blankly at Miguel or walk away. This kind of pattern would sometimes escalate to the point where Atticus' anger would explode, and he would yell back. Unlike Miguel's anger, which was intended to get

engagement from Atticus, when Atticus got angry and yelled it was to push Miguel away and create space between them.

Equally important to understanding the reactive parts of their cycle is exploring the primary emotions "usually excluded from individual awareness and not explicitly addressed in the partners' interactions" (Johnson, 2019b, p. 132). In this case, Miguel talked about how scared he was; in a time of need Atticus was just not there, "it's like he abandons me!" he said with tears in his eyes. Miguel went on, "it's like my country abandoned me, my city abandoned me, I'm scared…a lot! How can he not see that!?!" At this stage of therapy, the therapist is working with Miguel and Atticus to explore their emotional responses and attachment longings in the relationship. The therapist's task is to keep them engaged in this exploration and help each partner engage more fully (Johnson, 2019b).

The therapist then turned to Atticus, reflected how much he knew he loved and cared for Miguel and was curious about what was happening on the inside for him. This was a challenging conversation for Atticus; unsure, he offered that he was "frustrated." The therapist validated and continued to explore "frustrated" with Atticus. He started to talk about whether he would ever be enough for Miguel, saying "sometimes I wonder if anything I do matters, I love him more than anything in the world, always think about him before making any decisions, and…I don't know…" The therapist reflected, "it's like you'll never be enough for Miguel?" to which Atticus responded "I guess." As Atticus said that, the therapist reflected about the "moisture in his eyes" and wondered if he was sad about not being enough for Miguel. Atticus said "who wouldn't be? It's a sad situation."

At this stage of couple work, there is an active engagement in, and focus on, the emotional experiences of each partner. Therapists work collaboratively with couples to make sense of how attachment needs and primary emotions shape their interactional patterns that have been having a negative impact on the relationship. Once identified, the negative interaction cycle is externalized and identified as a goal for change in therapy (Johnson, 2019b). For gay male couples, this can also require integrating and externalizing societal ignorance, prejudice, fear, and the human tendency to conform to dominant norms as part of the negative cycle (Allan & Johnson, 2017). Combating years of prejudice and "the historical lack of a unified national legal framework to govern formation and dissolution of couple relationships has left many same-sex couples in a sea of uncertainty" (Green & Mitchell, 2015, p. 499).

The therapist worked over a series of sessions to externalize and stabilize their negative interaction cycle. Therapists move into the next stage of couple work when couples begin to have experiential awareness of their negative interaction cycle and more vulnerable aspects are now explored to change interactional positions (Johnson & Denton, 2002). With an increased understanding of their negative interaction cycle and the ability to catch themselves when they start to escalate, Miguel and Atticus were ready to better understand what they needed to do to make the changes last.

The therapist started with Atticus knowing that the next important shift in therapy is "when the more withdrawn partner begins to become more active and engaged in the relationship" (Johnson, 2019b, p. 22). This shift involves a change in interactional position in terms of control and accessibility for contact. The withdrawn partner asserts his needs and wants, rather than stonewalling or avoiding the partner, becoming more and more emotionally engaged with the other in the therapy sessions.

As Atticus explored his sadness of not feeling enough for Miguel, the therapist deepened the emotion. Johnson (2019a) noted that an "increase in client levels of experiencing from early to late therapy also seems to be a stronger predictor of outcome than the working alliance" (p. 53). Atticus started to quietly weep and the therapist helped him talk to Miguel about his sadness of not feeling enough. Miguel was supportive and reassured Atticus; he shared his own sadness

in recognizing how disconnected Atticus felt from him when they were caught in their negative cycle. The therapist then asked Atticus what he needed from Miguel:

A: Ummm, I don't know, he's great, it feels funny to talk about what I need from him, he gives me so much.
Th: I know, you really took in his accepting you talking about your sadness of not feeling enough?
A: I did, it felt so good. (reaching across to hold Miguel's hand)
Th: Ok, I wonder if we can explore together what you need in those moments?
A: Ummm, sure.
Th: I remember you talking about how alone you felt when you brought up your HIV status.
A: Oh yeah, that's kind of a sore spot.
Th: Oh? Can you tell me more?
A: I'm healthy but sometimes I worry…Miguel always tells me not to worry, any one of us could be run over by a bus any day! But sometimes, I feel like I have a bus inside of me with my name on the license plate…
Th: Wow, that sounds really, really scary, lonely…
A: It is. I get so lost for words sometimes and don't know what to say…it's strange to talk abut this now…
Th: Are you ok if we continue to explore this Atticus?
A: Sure…you know, I think about how I could never be enough for my family, how they feel something's wrong with me, like I have a disease. They stay away from me, they don't now about this amazing man I'm married to, and no matter what I do I will never be enough for them!
Th: There's some sadness that comes up for you as you say that? (noticing his eyes watering)
A: Yes, you know I need Miguel, sometimes I need him the way I needed him the day I was diagnosed. I felt so safe in his arms that day, like I was gonna be ok, life was gonna be ok, I just felt so safe in his arms that day.

The therapist then helped Atticus talk to Miguel about that need and Miguel was accepting and more than willing. His usual strategy of telling Atticus everything was going to be ok was experienced as a brush off by Atticus and he wanted to be there when the fear and loneliness associated with HIV would emerge at times. Miguel told Atticus, "knowing that you feel safe in my arms makes me feel like I am doing what I told you that day in the clinic, that we're going to beat this together."

> Miguel and Atticus were both experiencing their negative cycle less and noticing it more explicitly when it did come up. Atticus was feeling more available and open to Miguel; he regularly checked in on him and noticed a reluctance from Miguel at times to talk about his day or how he was doing. Thinking he needed space, Atticus would leave him be, glad to feel closer and know that he could go to Miguel with his fears and that there is one person in the world he is enough for. Still, it stuck with Atticus, something did not seem quite right with Miguel.

The therapist worked to ensure that Atticus was clear about the parts of himself he had avoided because they were so painful—his not feeling enough, worries about his health, sadness, and his strategy of relying on himself as his only source of comfort. Atticus seemed more present in therapy; he expressed a stronger sense of safety in his relationship, and he talked about how he was able to carry this through when they were at home, not only in the therapy room. The therapist now turned his attention to Miguel to explore his attachment needs and vulnerabilities. Johnson (2019b) notes the next change event in therapy as a pursuer softening where as the pursuing spouse "becomes less angry, the less engaged partner risks more involvement; as this

involvement increases, the critical spouse allows [himself] to disclose needs and desires more openly. This then makes it easier for the less engaged partner to be responsive" (p. 22).

For the purpose of assembling Miguel's emotional experience, the therapist curiously explored the fear Miguel felt when people would yell insults at him. Johnson (2019a) describes this process as we "assemble them with the client into a whole that creates a sense of completeness…This then opens a door for further discovery and a deepening awareness of more hidden or unacknowledged emotions" (p. 57). In essence, clients are encouraged to make sense of and name the emotional changes they are seeking in therapy.

The therapist started with the trigger of Miguel being yelled and asked what happens to him in that moment:

M: It's like I get stopped in my tracks for a brief moment, hold my breath.
Th: Ok, where do you feel that in your body?
M: I get a heat sensation in my head, my chest, I feel pressure like a sunkenness, my heart sinks, it's like it's making my arteries harden, it's like a pain like someone punched me in the gut.
Th: Wow, that does sound painful, what do you say to yourself in those moments?
M: I tell myself that I know lots of people who are not like that, I try to relax, and then I have to go through the motions of trying to shake it off but I'm left with a gnawing feeling, annoyed, irritated…
Th: That's a lot Miguel, you are stopped in your tracks and notice this heat in your head and chest and then this sunken feeling in your body like your arteries are hardening and you are punched in the gut?
M: Yes.
Th: Then you're left with this gnawing feeling, annoyed, irritated. I'm curious what that feels like for you?
M: Scary…
Th: Ohhhh ok, scary and I wonder if you're alone?
M: I don't want to be but yes, when I try to talk to Atticus about it, I am left alone with all of those feelings.

The therapist then helped Miguel talk with Atticus about that experience and how scared, alone, and abandoned he felt in those moments. Atticus was receptive, telling Miguel "in all those times I want to let you know how much I love you and I don't see you in the way those other people do but I actually really missed *seeing* you." Atticus apologized and further reflected that his efforts to minimize differences and try to make Miguel feel equal blocked what Miguel most needed from him, and left Miguel feeling ignored and abandoned in a time of need. The therapist then explored what Miguel needs from Atticus when he is most scared:

M: I need him…I need to be me…I don't know I just need to not feel so scared all the time!
Th: Oh wow, Miguel, this is big and this is how important this guy is to you, when you are most scared you need him?
M: Of course, but I need him to get me, to want to know more about just how many times a week I hear something about being Mexican that makes me scared enough to wonder if he's going to leave because of who I am.
A: That never crosses my mind, I don't… (therapist interrupts).
Th: Can I slow you down Atticus, would you be ok if Miguel talks to you about what he needs from you when those fears come up for him?
A: Of course, I want that more than anything.

The therapist worked to facilitate Miguel talking about what he needed from Atticus. Miguel talked at length about how being a "brown person" in America right now is scary and "I need to know my

home is a safe place in the world that I can go to, that you're a safe person in the world I can go to." Miguel talked about the need to share his experiences with Atticus and for him to be interested and engaged. "I look at your eyes when I tell you about those experiences and if I don't see what I'm talking about in your eyes, I start to panic and get angry with you." Atticus was tearful, in part because he could see just how much he meant to Miguel and in part recognizing how many times he missed supporting Miguel in all the ways he wanted to. He reassured Miguel that he better understood and did want to respond to him, he also wanted to know what would happen if he did not get it right. The therapist helped the two of them talk about building a new cycle and there being some trial and error, that neither of them was going to get it right 100% of the time but they now knew how to talk to each other about those misses from a more vulnerable and engaging place.

Conclusion

Gay men enter therapy with a lifetime of sociocultural stressors, and building a strong romantic relationship is an important source of resilience to both buffer against ongoing stressors and develop an understanding of who each partner is as a gay man. The vulnerable reach to have attachment needs met not only contributes to building a stronger relationship but also helps gay men deal with those stressors on an ongoing basis. Using an approach that recognizes the importance of attachment bonds as central to building and sustaining relationships as a buffer against stressors helps therapists incorporate a variety of factors that gay male couples enter therapy with. Asking gay men to be vulnerable and reach for each other from primary emotion is asking them to reach across adaptive strategies they have developed to deal with microaggressions and larger, systemic aggressions that have both gendered expectations of vulnerability and cultural expectations of what love is for gay men. The therapist's role is to hold and understand both the vulnerability of reaching for reciprocal care and support from his partner while understanding the reach has to also cross fears of rejection based on prejudice and discrimination.

> Miguel and Atticus ended therapy with the option to return if they felt like they needed some help or a "tune-up." They both experienced a deeper sense of commitment to each other as well as an ease talking more vulnerably with each other. Atticus started noting events that were reported in the news to Miguel, wondering how he was doing. Miguel appreciated the efforts, it felt good to know that Atticus was tracking things that mattered to him and that the burden he experienced was shared in some way. They stumbled sometimes, getting caught in their old cycle and had a greater ability to recognize it and recover more quickly and do so in a way that felt genuinely reparative.

Johnson (2019b) notes that the last process of change "concerns the consolidation of the new, more responsive positions both partners now take in the interaction, and the integration of the changes made in therapy into the everyday life of the relationship and into each person's sense of self" (p. 186). Miguel and Atticus also started to appreciate the connections they did have in their lives. While Atticus' family continued to struggle with his being gay, the couple had acceptance and important connections with Miguel's family. As Ryan et al. (2010) note, being valued and acknowledged by parental figures can help gay men have the courage to explore and develop all aspects of themselves, including the capacity to build vibrant, loving relationships. They both settled further into knowing they were enough, valued, and important to other people in ways that created sustaining connections and a source of support and resilience in their lives. Bowlby (1998) noted that it is safer for the child to say I am a bad child than to say I have a bad parent, that it would be terrifying for the child to conclude they have a bad parent. For some gay men whose families do not accept them, there may be a transition to de-normalizing their family as a sole reference point for how they view themselves and others as sources of contact, care, and comfort. For these gay men to accept supports and new sources of resilience into their lives means grieving that some part of their parents is wrong.

The therapist in this case understood how experiences of marginalization and oppression could magnify their negative interaction cycle. With a continued focus on guiding a process that highlighted attachment needs and used emotion to facilitate change events, the therapist understood from the start that their bond was an important source of resilience for whatever experiences that Miguel and Atticus had in the world or with their families. By starting the therapy process with broaching, the therapist laid out topics that can be explored throughout therapy. The therapist further integrated how experiences of marginalization can heighten attachment needs and the negative interaction cycle. Seamlessly integrating those discussions into all phases of therapy helps couples engage in challenging conversations in ways that facilitate bonding conversations and attend to each other's attachment needs.

References

Ainsworth, M. D. S. (1985). Attachments across the life span. *Bulletin of the New York Academy of Medicine, 61*(9), 792–812.

Allan, R., & Johnson, S. M. (2017). Conceptual and application issues: Emotionally focused therapy with gay male couples. *Journal of Couple & Relationship Therapy, 4*(1), 286–305. https://doi.org/10.1080/15332691.2016.1238800

Allan, R., & Westhaver, A. (2017). Attachment theory and gay male relationships: A scoping review. *Journal of GLBT Family Studies, 14*(4), 295–316. https://doi.org/10.1080/1550428X.2017.1347076

Ballotpedia. (n.d.), *Civil Rights Act of 1964.* https://ballotpedia.org/Civil_Rights_Act_of_1964

Black, D., Gates, G., Sanders, S., & Taylor, L. (2000). Demographics of the gay and lesbian population in the United States: Evidence from available systematic data sources. *Demography, 37*(2), 139–154. https://doi.org/10.2307/2648117

Bowlby, J. (1998 [1973]). *Attachment and loss: Separation* (Vol. 2). Pimlico.

Campbell, L., Simpson, J. A., Boldry, J., & Kashy, D. (2005). Perceptions of conflict and support in romantic relationships: The role of attachment anxiety. *Journal of Personality and Social Psychology, 88*(3), 510–531. https://doi.org/10.1037/0022-3514.88.3.510

Day-Vines, N. L., Wood, S. M., Grothaus, T., Craigen, L., Holman, A., Dotson-Blake, K., & Douglass, M. J. (2007). Broaching the subjects of race, ethnicity, and culture during the counseling process. *Journal of Counseling & Development, 85*(4), 401–409. https://doi.org/10.1002/j.1556-6678.2007.tb00608.x

De la Garza-Mercer, F., Christensen, A., & Doss, B. (2006). Sex and affection in heterosexual and homosexual couples: An evolutionary perspective. *Electronic Journal of Human Sexuality, 9,* pNA.

Domingue, R., & Mollen, D. (2009). Attachment and conflict communication in adult romantic relationships. *Journal of Social & Personal Relationships, 26*(5), 678–696. https://doi.org/10.1177/0265407509347932

Elizur, Y., & Mintzer, A. (2003). Gay males' intimate relationship quality: The roles of attachment security, gay identity, social support, and income. *Personal Relationships, 10*(3), 411–435. https://doi.org/10.1111/1475-6811.00057

Feeney, J. A. (2008). Adult romantic attachment: Developments in the study of couple relation- ships. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment theory and research* (2nd ed., pp. 456–481). Guilford.

Feeney, J. A., & Noller, P. (1996). *Adult attachment*. Sage.

Feeney, J. A., & Noller, P. (2004). Attachment and sexuality in close relationships. In J. H. Harvey, A. Wenzel, & S. Sprecher (Eds.), *The handbook of sexuality in close relationships* (pp. 183–201). Lawrence Erlbaum Associates.

Flores, A. R. (2019). On transnational networks and coming out: Reflections from LGBT politics in the United States. *Politics, Groups, and Identities, 7*(2), 458–461. https://doi.org/10.1080/21565503.2019.1616936

Gentzler, A. L., & Kerns, K. A. (2004). Associations between insecure attachment and sexual experiences. *Personal Relationships, 11*(2), 249–265. https://doi.org/10.1111/j.1475-6811.2004.00081.x

George, C., Kaplan, N., & Main, M. (1985). *Adult Attachment Interview* (Unpublished manuscript). University of California.

Green, R. J., & Mitchell, V. (2015). Gay, lesbian, and bisexual issues couples in therapy. In A. S. Gurman, J. L. Lebow, & D. K. Snyder (Eds.), *Clinical handbook of couple therapy* (5th ed., pp. 480–511). Guilford.

Herek, G. M., Norton, A. T., Allen, T. J., & Sims, C. L. (2010). Demographic, psychological, and social characteristics of self-identified lesbian, gay, and bisexual adults in a US probability sample. *Sexuality Research & Social Policy, 7*(3), 176–200. https://doi.org/10.1007/s13178-010-0017-y

Johnson, S. M. (2019a). *Attachment theory in practice: Emotionally focused therapy (EFT) with individuals, couples, and families*. Guilford.

Johnson, S. M. (2019b). *The practice of emotionally focused couple therapy: Creating connection* (3rd ed.). Brunner-Routledge.

Johnson, S. M., & Denton, W. (2002). Emotionally focused couples therapy: Creating connection. In A. S. Gurman (Ed.), *The clinical handbook of couple therapy* (3rd ed., pp. 221–250). Guilford.

Jordan, J. V. (2009). *Relational-cultural therapy*. American Psychological Association.

Julien, D., Chartrand, E., Simard, M. C., Bouthillier, D., & Begin, J. (2003). Conflict, social sup- port, and relationship quality: An observational study of heterosexual, gay male, and lesbian couples' communication. *Journal of Family Psychology, 17*(3), 419–428. https://doi.org/10.1037/0893-3200.17.3.419

Kaslow, F., & Robison, J. A. (1996). Long-term satisfying marriages: Perceptions of contributing factors. *American Journal of Family Therapy, 24*(2), 153–168. https://doi.org/10.1080/01926189608251028

Kobak, R. R., & Sceery, A. (1988). Attachment in late adolescence: Working models, affect regulation, and representations of self and others. *Child Development, 59*(1), 135–146. https://doi.org/10.2307/1130395

Kurdek, L. A. (1997). The link between facets of neuroticism and dimensions of relationship commitment: Evidence from gay, lesbian, and heterosexual couples. *Journal of Family Psychology, 11*(4), 503–514. https://doi.org/10.1037/0893-3200.11.4.503

Kurdek, L. A. (1998). Relationship outcomes and their predictors: Longitudinal evidence from heterosexual married, gay cohabiting, and lesbian cohabiting couples. *Journal of Marriage and Family, 60*(3), 553–568. https://doi.org/10.2307/353528

Mackey, R. A., Diemer, M. A., & O'Brien, B. A. (2004). Relational factors in understanding satisfaction in the lasting relationships of same-sex and different-sex couples. *Journal of Homosexuality, 47*(1), 111–136. https://doi.org/10.1300/J082v47n01_07

Meyer, I. H. (2013). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychology of Sexual Orientation and Gender Diversity, 1*(S), 3–26. https://doi.org/10.1037/2329-0382.1.S.3

Mikulincer, M., & Nachshon, O. (1991). Attachment styles and patterns of self-disclosure. *Journal of Personality and Social Psychology, 61*(2), 321–331. https://doi.org/10.1037/0022-3514.61.2.321

Mohr, J. J. (2008). Same-sex romantic attachment. In J. Cassidy & P. R. Shaver (Eds.), *Handbook of attachment theory and research* (pp. 482–502). Guilford.

Mohr, J. J., & Fassinger, R. E. (2003). Self-acceptance and self-disclosure of sexual orientation in lesbian, gay, and bisexual adults: An attachment perspective. *Journal of Counseling Psychology, 50*(4), 482–495. https://doi.org/10.1037/0022-0167.50.4.482

National Coalition of Anti-Violence Programs. (2017). *Lesbian, gay, bisexual, transgender, queer, and HIV-affected hate violence in 2016. A 20th Anniversary report from the National Coalition of Anti-violence programs.* http://avp.org/wp-content/uploads/2017/06/NCAVP_2016HateViolence_REPORT.pdf

Peplau, L. A., & Fingerhut, A. W. (2007). The close relationships of lesbians and gay men. *Annual Review of Psychology, 58*(1), 405–424. https://doi.org/10.1146/annurev.psych.58.110405.085701

Ramirez, O. M., & Brown, J. (2010). Attachment style, rules regarding sex, and couple satisfaction: A study of gay male couples. *Australian and New Zealand Journal of Family Therapy, 31*(2), 202–213. https://doi.org/10.1375/anft.31.2.202

Ryan, C., Russell, S. T., Huebner, D., Diaz, R., & Sanchez, J. (2010). Family acceptance in adolescence and the health of LGBT young adults. *Journal of Child and Adolescent Psychiatric Nursing, 23*(4), 205–213. https://doi.org/10.1111/j.1744-6171.2010.00246.x

Safran, J. D., Muran, J. C., & Eubanks-Carter, C. (2011). Repairing alliance ruptures. In J. C. Norcross (Ed.), *Psychotherapy relationships that work: Evidence-based responsiveness* (2nd ed., pp. 224–238). Oxford University Press.

Sherry, A. (2007). Internalized homophobia and adult attachment: Implications for clinical practice. *Psychotherapy, 44*(2), 219–225. https://doi.org/10.1037/0033-3204.44.2.219

Thoreson, R. (2018). *"All we want is equality": Religious exemptions and discrimination against LGBT people in the United States.* https://www.hrw.org/report/2018/02/19/all-we-want-equality/religious-exemptions-and-discrimination-against-lgbt-people

Tunnell, G. (2012). Gay male couple therapy: An attachment-based model. In J. J. Bigner & J. L. Wetchler (Eds.), *Handbook of LGBT-affirmative couple and family therapy* (pp. 25–42). Routledge.

Wang, C.-C. D., Schale, C. L., & Broz, K. K. (2010). Adult attachment; lesbian, gay, and bisexual Identity; and sexual attitudes of nonheterosexual individuals. *Journal of College Counseling, 13*(1), 31–49. https://doi.org/10.1002/j.2161-1882.2010.tb00046.x

5
Illuminating Strengths
Multiracial Feminist Couple Therapy with Queer Women

MONTINIQUE MCEACHERN, DEBORAH COOLHART and DYANE WATSON

Sydney and June initially sought couples therapy after noticing that their fights had become more frequent and intense. The two stated that they had specifically sought a queer woman therapist to work with. Sydney, a 36-year-old white bisexual cisgender woman, and June, a 32-year-old Black lesbian cisgender woman, both describe growing up in working-class single-parent households and currently reside in Brooklyn. The two met four years ago at an open mic night and became fast friends. After acknowledging that their time together felt more intimate than friendship, the two started dating and have been together ever since. They discussed bonding over a love for poetry and shared feminist politics, as well as a mutual erotic attraction.

Six months into their relationship, June lost her apartment due to a rent increase and the two decided to move in together. Sydney points to this as the first "rough patch" for the two of them as she doubted if it was still too early in their relationship to cohabitate. By the end of their first year, however, both agreed that their relationship felt secure. June shared that, from her perspective, their first "rough patch" happened around two years ago when the two visited Sydney's mother in Minnesota. She shared that she was offended by Sydney's mother not acknowledging her and felt distant from Sydney during the trip. June expressed that their sexual intimacy never "recovered" from the distance they felt during the trip. This felt particularly hurtful to June because she experiences her mother as supportive of her relationship with Sydney and reports that Sydney and her mom even talk on the phone. Further, June shared that she is personally frustrated with the level of financial stress she has experienced over the past few years and feels as if Sydney over-emphasizes that she (Sydney) financially supports the two of them. June discussed the unfair treatment she experienced at work and the unhealthy environment her supervisor created through treating her differently from white employees. She left her job three months ago, but still has to be "June," taking care of her aging mom, being a loving partner, and searching for a new job.

While Sydney noticed these struggles, she reported that their primary issue was a "difference in communication styles." She too felt distant from June during the visit to her mom, but felt torn between supporting her partner and spending time with her mother, who she does not get to see often. Sydney shared that she wanted the two of them to "move past" the visit and thought visiting her mom without June would be a solution to the tension. Both agreed that they would like to be more physically and sexually intimate in their relationship.

June and Sydney illustrate common issues queer women couples present to therapy with: navigating interracial relationships, challenges with family of origin relationships, struggles with sexual intimacy, and other "rough patches." In this chapter, we explore the specific challenges and strengths queer women couples experience and overview what the field of couples therapy has come to know about queer women couples. Further, we present a

DOI: 10.4324/9780429274626-8

multiracial feminist therapy approach for work with queer women couples like June and Sydney, informed by our experiences as couples therapists committed to utilizing an intersectional feminist lens in couples therapy.

Therapy with Queer Women Couples: Multiracial Feminist Therapy Considerations

Queer women couples are a richly diverse group and challenge many of the social assumptions and even the language around couples therapy. Impacted by multiple systems of oppression and marginalization, queer women couples also have unique ways of forming and maintaining relationships. In order to discuss experiences of queer women couples, it is first necessary to define who we are referring to by using this terminology. While the term "lesbian" may seem like a fit to describe the couples in this chapter, societal understandings of sexuality and gender have become much more expansive in recent years. Women who are partnered together may identify with any number of sexual identity labels that may not be accounted for by referring to their partnerships as "lesbian relationships." For example, June identifies as a lesbian; however, she is partnered with Sydney, a bisexual woman who is attracted to people of her same gender and other genders. To label their relationship, a "lesbian" relationship may miss some of the social context and political implications of their identities. Further, it may not leave room in sessions to discuss the erasure or biphobia Sydney experiences. Therefore, we chose to use "queer" to describe these couples for the purposes of this chapter—and for how we understand sexuality. We use the same term to describe women of all sexual identities who are partnered with another woman.

Understanding the complexities of gender, we use the term queer as an inclusive term for cisgender women—women who identify with the sex assigned at birth—and women who are transgender—not identifying with the classification of sex assigned to them at birth. The term is also inclusive of nonbinary femme folks and folks who were assigned female at birth, but identify as nonbinary. Although the term is not universally used and embraced in lesbian, trans, bisexual, and pansexual communities due to prior derogatory use, it is more inclusive and encompassing of the diversity among nonheteronormative women populations than popularized terms and acronyms currently used in literature—such as LBT (Singh & Chun, 2010). Additionally, the term queer has passionately been reclaimed by LGBT activists, academics, and advocates in recent years. Queer is now often referred to as a resistance term, reclaimed through political work by the community it used to subjugate (Addison & Coolhart, 2009). Other terms such as homosexual or transsexual have pathological roots, coined as medical diagnoses, and will therefore not be used. Additionally, they assume gender and sexuality are dichotomies and miss the innumerable sexualities and genders that fall under the queer umbrella. Further, the term queer allows the added ability to frame populations positively, as opposed to what it is not, e.g. non-heterosexual or not cisgender.

Societal Issues Faced

Queer women couples actively resist multi-systemic oppression while forming and maintaining romantic relationships. Significant strides toward LGBTQ inclusion have been made in recent U.S. society, namely the passing of marriage equality in 2015, but with increasing anti-trans and anti-reproductive health legislation being passed, there is still much work to be done. Despite remarkable displays of resilience in the face of these systems of oppression (Connolly, 2012), the impact of cultural oppression is still salient for queer women when they are in relationships (Addison & Coolhart, 2009). Given the recent increase in political hostility toward queer populations, racial minority groups, and women in the U.S. due to the current political administration in this country, threats to daily life for queer women are even more relevant to discuss. Explorations into sexual identity have often ignored other systems of oppression

that may also impact queer people. Similarly, works focused on gender have historically overlooked other forms of oppression, namely white supremacy. In response to these challenges, more recent works highlight and examine the ways in which systems of oppression are co-constructed (Zinn & Dill, 1996).

Women of color feminists have long challenged patriarchy and homophobia, asserting that racial oppression situates their experiences of heterosexism differently than how white women experience heterosexism (Zinn & Dill, 1996). Therefore, when working with queer women couples, therapists must use an intersectional approach, understanding that the societal oppression is not experienced through one of their identities, but by a matrix of identities simultaneously (Collins, 2000). While Sydney's mother may have been refusing to acknowledge June due to queerphobia, for example, they are both aware of the racism inherent in this act as well. As a couple, they can empathize with each other around ways queerphobia impacts them, but Sydney often has to be made aware of the ways June has to navigate queerphobia differently as a Black woman.

To effectively work with queer women couples, it is imperative to understand the social climate in which they form and maintain relationships. The triad of cultural oppression described by Connolly (2012) highlights the ways in which heterosexism, homophobia, and the internalization of both undergird the experiences of all queer women relationships. In the contemporary cultural climate, it is important to acknowledge that the triad of cultural oppression is informed by other social identities queer women hold, such as their racial identity, citizenship status, socioeconomic status, and ability status. Heteronormativity, the social process that holds heterosexuality as superior to all other relational identities, is experienced differently based on queer women's other social identities. Queer women couples navigate direct and implicit forms of oppression caused by the interconnectedness of racism, heterosexism, classism, misogyny, transmisogyny, ableism, and a host of other systems of marginalization and domination.

For June and Sydney, an interracial couple and a mixed orientation couple, racism and biphobia impacted them not only externally, such as at June's job, but also internally, causing them to struggle against each other around experiences of oppression. For example, Sydney worked in session to expand her understanding of racial microaggressions that June experiences, particularly from her mother, and how she could support her in those moments. While both partners were raised in similar class backgrounds and share a queer social support network of friends and chosen family, significant cultural and identity differences inform their communication styles and the ways in which their families receive them as a couple. As a therapist, I (MM) made space for this difference by attending to the difficulties and pain each of them reported. Sydney reflected on what racial implications her mother ignoring June had. She shared that she initially perceived the incident as bierasure due to her mother frequently stating that she could "still marry a man." After having explicit conversations about race in session, she was able to name how her mother refusing to acknowledge the presence of her Black girlfriend was an experience that was situated at the intersections of biphobia and anti-Black racism. Exploring how this incident impacted both of them addressed multiple axes of their identities while placing the onus of responsibility on heteronormativity and racism.

Strengths of Queer Women Couples

Despite the challenge of systemic oppression, queer women in relationships with women have many unique strengths. Queer women couples show strengths related to forming initial emotional connections and foundations for romantic love (Connolly, 2012). This may in part be because queer women—unlike nearly every other demographic of those seeking relationships—overwhelmingly resist the app-focused trend of meeting someone. While

some queer women form romantic relationships online, queer women for the most part continue to meet in places where queer women have traditionally had strong presences, such as brick-and-mortar bars and bookstores, or through friends (Lang, 2017). Because queer women are often meeting in and through spaces in which they have shared interests, queer women couples are more likely to have shared values, which contributes to connectedness. Additionally, queer women couples are more likely to ritualize the love in their relationships than other relationship configurations, celebrating special occasions and creating couple rituals (Connolly, 2012).

Earlier studies on queer women couples suggested that having similar gender socialization experiences increases understanding in the relationship (Ossana, 2000) and contributes to emotional connectedness (Scrivner & Eldridge, 1995). It is important to note here that the process of gender socialization may be dissimilar for queer women in relationships with one another depending on other aspects of their identities and gender expressions. Similar studies have also suggested that queer women couples are effective at conflict resolution and empathic attunement to one another, and report an increased satisfaction in their relationship as a result (Connolly & Sicola, 2005). Further, queer women couples report low frequency of abusive behaviors, high relational commitment, and high sexual satisfaction within their relationships (Bryant & Demian, 1994).

The early phase of sessions with June and Sydney consisted of opening space for their relationship story to be told, thickening descriptions around aspects of their relationship that had become assumed and rehearsed. Illuminating strengths, such as their shared values and interests that caused them to bond initially, comprised the bulk of the early work in session, allowing for both June and Sydney to remember the point in their relationship when arguments and distance did not cause as much stress as they currently are. Illuminating the strengths that their current difficulties distorted allowed more room for them to see their relationship as not just a sum of "rough patches," but the meaningful partnership they created. It also allowed them space to name the support they have from friends, the ways they celebrate one another, and revisit things they used to do with one another for fun that the stress of navigating identity-based oppression too often did not allow for. Before exploring further what was helpful for Sydney and June, it is important to review what relational therapists have already researched regarding queer women couples.

Literature Review

According to a systematic review of LGB research samples in couple and family therapy journals from 1975 to 2015 by Hartwell and colleagues, the current body of family therapy research regarding LGB people has over-focused on the experiences of men and white people, and often neglects to include the experiences of bisexual people (Green et al., 2009; Hartwell et al., 2017; Henke et al., 2009; Hernández & Rankin, 2008; McGeorge & Carlson, 2010). Henke and colleagues even suggest that relational therapists may be greatly overestimating their ability to provide affirmative therapy to LGB clients, given this lack of inclusion of women, bisexual folks, and people of color when sampling queer populations (Henke et al., 2009). So, while it is important to be aware of what we "know" from the literature about queer women couples, it is important to consider that we do not know how much these findings can be generalized to LGB people occupying multiple marginalized identities. This literature review summarizes many of the broad concepts that have been written about queer women couples, thinking critically about how intersectional identities may or may not fit into this framework. Concluding this section is a review of the few studies that have explored the unique experiences of queer women of color (QWOC) and their couple relationships.

Minority Stress

Queer women couples experience minority stress (Meyer, 2003), the effects of social oppression, such as heterosexism, internal and external homophobia, and rejection by families and communities (Brown, 1995; Connolly, 2004; Green & Mitchell, 2015; Otis, Rotosky et al., 2006). Researchers have found relationships between minority stress and variables such as relationship quality, domestic violence, health, and substance abuse among sexual minority women (Balsam & Szymanski, 2005; Lehavot & Simoni, 2011). One facet of minority stress, internalized homophobia, can lead to lowered self-esteem and increased loneliness (Szymanski & Chung, 2001) as well as increased depression (Szymanski, Chung et al., 2001) for queer women. When thinking about couples, psychological distress in one or both partners can lead to decreased relationship satisfaction, increased conflict, and decreased levels of commitment (Otis, Riggle et al., 2006; Riggle et al., 2010).

Additionally, authors have explored how multiple minority stressors impact LGBT people of color. Balsam et al. (2011) found that LGBT participants reported racism in LGBT communities, heterosexism in racial/ethnic minority communities, and racism in dating and close relationships. Attending to racism that may be occurring within couple relationships may be particularly important since same-gender couples are more likely to partner with a person of a different race, ethnicity, religious background, age group/generation, educational attainment, and/or socioeconomic status (Connolly, 2004; Ritter & Terndrup, 2002). Specifically looking at the experiences of Black lesbians, Bowleg et al. (2003) found that participants discussed racism as a common and significant stressor and that they contextualized their experiences of sexism and heterosexism through the prism of racism, providing support for the "triple jeopardy" experience of Black lesbians (Greene, 1994). For example, June often discussed dressing in more feminine ways to combat being seen as "too masculine" not just because she is a lesbian, but also because of the ways racism masculinizes Black women.

Gender Role Socialization

In same-gender couples, there is a need to negotiate roles and activities because there is no gender role "script" for queer partners (Addison & Coolhart, 2009; Green & Mitchell, 2015). This can leave freedom for couples to negotiate roles, often leading to increased egalitarianism in queer women couples (Bigner, 2000). Early family therapy literature tended to pathologize queer women couples for being merged, fused, or enmeshed; however, strength-based interpretations of the closeness in queer women relationships have also been discussed, such as viewing this closeness as an adaptive response to adverse conditions (Biaggio et al., 2002).

Additionally, the gender role socialization of two women in a partner relationship may lead to strength in terms of the way they deal with stress and engage in conflict. According to Taylor et al. (2000), in times of stress, women may be more likely to respond in a "tend and befriend" manner, rather than a fight or flight response. This response can lead to increased safety, reduced distress, sharing of resources and responsibilities, thus reducing feelings of vulnerability (Taylor et al., 2000).

These strengths in queer women relationships may contribute to their higher reported relationship quality (Kurdek, 2008). However, there can be potential negative effects of being coupled with a partner who received similar gender socialization, sometimes resulting in more of the same or similar deficits being brought to the relationship (Connolly, 2004; Green & Mitchell, 2015; Greenan & Tunnell, 2003; Ritter & Terndrup, 2002). Although Green et al. (1996) found that enmeshment did not generally characterize queer women couples, it may be more likely for queer women couples to experience enmeshment when both partners are highly gender-conforming (e.g. when both women in a couple are very nurturing and yielding).

Parenting Challenges

Some literature has discussed parenting challenges for same-gender couples, including raising children from prior heterosexual relationships, and creating or adopting children within the same-gender partnership (Brown, 1995; Ritter & Terndrup, 2002). Queer families by definition usually have family systems with one or more nonbiological parents; the stressors on such families can then be complicated by the impact of heterosexism and cissexism—the belief that cisgender people's gender expressions and embodiments are more natural and legitimate than those of trans people—from society, extended family, other biological parents, and even the children themselves depending on their ages (Addison & Coolhart, 2015). While having diverse family structures and multiple parents has been viewed as challenges, for many families, these various family dynamics can also be a strength, providing additional emotional and financial resources and increased flexibility. Queer parents must also make decisions such as how to answer children's questions, how to manage family information outside the home, and how to handle attacks on their parenting abilities or rights. Such decisions may be sources of conflict or splits in the couple system (Addison & Coolhart, 2015). As will be discussed later, queer women couples embedded in racial minority communities and/or religious communities may also face challenges in being validated as couples or families.

Being "Out"

Several authors have pointed to challenges for same-gender couples due to differences in partners' degree of "outness" (Brown, 1995; Connolly, 2004). For example, how long each partner has identified as queer and whether each has come out in various aspects of their personal lives, such as work, family of origin, and community, can be a source of conflict. This issue also encompasses those coming out of heterosexual marriages later in life, and the biphobia that some bisexually identified people experience from gay- or lesbian-identified partners (Addison & Coolhart, 2009).

Being out does not indicate superior mental health or stronger differentiation of self, and women may make decisions around being out based on the potential political consequences of being out (Green, 2000, 2002). Thus, Connolly (2012) suggested thinking in terms of "identity management," rather than all or nothing thinking about being out or not. For example, women may be balancing their relationships with racial, ethnic, and/or religious communities in which the consequences of coming out would be detrimental to other aspects of identity.

Research on QWOC and Couples

Research specifically on QWOC and couples is sparse, although some recent studies have begun to shed light on these experiences. Most studies have focused specifically on Black experiences. Wilson et al. (2011) explored the experiences of oppression and health outcomes, focusing on Black lesbian and bisexual women. Participants in this study listed many forms of oppression not typically considered in discussions of oppression with queer Black women, such as weight-based oppression and ageism. Higher body mass index levels predicted experiences of weight-based oppression, higher levels of depression, and lower levels of perceived health. This suggests that not only should race be considered as an important part of identity, but other intersectional aspects of identity such as weight and age should also be considered.

Glass and Few-Demo (2013) explored the complexities of social support arrangements for Black lesbian couples. Couples in the study discussed ways they experienced social support from three main communities: family of origin and extend family, church, and lesbian communities. The most significant source of social support reported by the couples came from family members, specifically biologically-related women. Extended family members of the women in

the couples supported them individually in their roles, such as mothers and daughters, but not necessarily in their roles as partners and as a couple. Also, extended family members supported the partner of their Black lesbian relatives as members of their racial community, but not as the sexual partners of their relative. Couples also reported that their partners were accepted as "helpful friends" instead of romantic partners.

Couples in Glass and Few-Demo's (2013) study also reported that their local LGBTQ communities provided occasional social support, reporting challenges for couple/family participation due to the focus on nightlife. However, couples reported strong support for their family, where other lesbians often provided childcare for the couple. Lastly, the couples reported church as a source of social support and that while being connected to a church community was important for them, they often did not feel comfortable disclosing their sexuality or relationship within these communities. Within church communities, the couples deemphasized their roles as lesbians and partners, and emphasized their roles as mothers and sisters. They described making their relationships "invisible" for church, and attending church for themselves, not for the couple relationship. This study lends support for the previously discussed idea of "identity management" as well as the need to consider religion as an important intersectional identity.

Battle and Harris (2013) examined the impact of community support, the importance of sexual orientation, and racial identity on sociopolitical involvement for queer Latina women. Results suggested that greater connections to the LGBT community and being out about queer identity were associated with higher levels of LGBT-related sociopolitical involvement. Participants who were more comfortable within the LGBT community reported less political involvement related to people of color issues. Also, the more support participants had from people of color communities, the less likely they were to participate in people of color activism. This study then also speaks to the concept of identity management and the impacts of feeling accepted for all aspects of self in their different communities.

Glass (2014) explored Black lesbian couples' experiences of negotiating family rituals. Participants reported that being involved in family rituals was an essential part of their identity as Black women. The theme of drawing a sense of strength and connection to community emerged from the interviews conducted. Interviewees also described having to manage their identities by hiding the nature of their romantic relationship so that validation of their partnership from extended family rituals and/or churchgoing experiences was not possible. Glass (2014) concluded that this caused a broken acknowledgment of multiple identities and that the partners only experienced partial identity acknowledgment from participating in family rituals.

Brooks (2016) examined how Black transgender and lesbian women negotiate their identities and stay within their racial communities. The study explored how homophobia and transphobia in the Black community and racism in the LGBT community shape the identity management of LGBT Black women, calling this negotiation "staying in." Staying in is defined by two stances the women chose to take: being out in relation to their queerness in the Black community, but not advocating for LGBT politics; or being out in Black spaces and being politically active around LGBT issues within Black community spaces—as opposed to being active in white LGBT spaces. In other words, some women chose to stay in their communities and educate Black people about LGBT identities rather than identifying with mainstream (white) LGBT politics due to the embedded issues of race and class. In both cases, "staying in" meant being out about their queerness.

Participants in Brooks' (2016) study reported a feeling of belonging; having family in the community created a sense of safety and family in the neighborhood. Similarly, other participants

reported that remaining in the neighborhoods they grew up in felt safer than relocating to the "gayborhood" due to these connections. "Lesbian visibility," discussed mostly by masculine lesbians in the sample, reported mixed experiences with their visibility within the community. One theme that emerged was "passing as one of the boys" which kept them safe within the neighborhood. Another theme was the lack of safety on public transportation, being asked for their identification in spaces where other people were not, or experiencing street harassment from men. Transgender women in the sample similarly reported unsafe experiences while commuting using public transportation.

McEachern (2020) explored the experiences of QWOC couples who were also engaged in political activism. Unique strengths of these couple relationships included both partners growing together in both their feminist politics and in their personal identities in the relationship. Another strength these couples reported was intentionality around communication, having explicit agreements around when they would see each other, the depth of their communication, and dealing with conflict as it happened. Additionally, these QWOC couples described experiencing their relationship as a "safe spot," or a space away from having to experience microaggressions or explain their identities.

Using a Multiracial Feminist Couples Approach with Queer Women

Feminist theory has led the way in examining not only psychological factors, but gendered factors that influence relational processes (Sharf, 2008). Women of color feminists have also challenged hegemonic patriarchy, heterosexism, and white paternalism since the inception of feminist thought (Zinn & Dill, 1996). Feminist theory continues to grapple with the impact of living in a society in which white men have historically restricted the autonomy of other groups (white paternalism), and have structured gender in a way that privileges cisgender maleness (hegemonic patriarchy). Heterosexism—the centering of heterosexuality as the default or "normal" sexual orientation and discriminating against all other couples—follows then as a byproduct of patriarchy. This is not only felt at the macro level, as evidenced by the modern civil rights movements or women's liberation efforts, but also on very intimate levels for queer women. Sydney, for example, shared in one session her hesitation to display a photo of her and June on her desk at work, fearing what coworkers might say regarding her sexual orientation. This is a negotiation of identity that has to be made because heterosexism leads us to assume that everyone is heterosexual until they disclose otherwise.

Since all of these processes shape the conditions that queer women form and maintain relationships in, these systems must be addressed with a critical social justice approach in couples therapy. By adopting a conceptual framework Baca Zinn and Thornton Dill described as multiracial feminism—a body of work that situates women in multiple systems of oppression, acknowledging that race is a power system that interacts with other forms of marginalization and inequality—work with queer women couples can more effectively address their relational issues. A multiracial feminist approach to therapy with queer women couples addresses multiple axes of identity and power and how they overlap for the couple, develops a shared language that affirms their relationship, and considers the therapist's identities and world views in the therapeutic process.

Addressing Multiple Axes of Identity and Power

Family therapy literature discusses social justice and intersectionality, both concepts which find their roots in early writings by Black feminists. The Combahee River Collective Statement is one of the earliest written feminist statements on exploring intersections of oppression. Members of The Combahee River Collective authored a statement in 1977 that discussed "simultaneity,"

which asserted that their lives as women were profoundly molded by the simultaneous experiences of sexual identity, race, class, and ability (The Combahee River Collective, 2014). Audre Lorde (2017) explains that the social establishments in the U.S. are based on a "mythical norm" defined as white, thin, male, heterosexual, Christian, able, and financially secure. In order to maintain that mythical norm, racism, sexism, and other forms of oppression as we know them became necessary evils for maintaining power (Lorde, 2007). Those of us who stand outside of that norm in one way or another experience the trappings of the power that resides in that mythical identity. Black feminism asserts that while our oppressions are inextricably tied to one another, so too is our liberation. Understanding racism can give us more information on dismantling gender binaries, for example.

Years after The Combahee River Collective introduced "simultaneity," Kimberlé Crenshaw introduced intersectionality to feminist theory. Crenshaw described intersectionality as simultaneity on a systemic level. Intersectionality refers to the ways in which oppressive institutions such as racism and classism are interconnected and cannot be examined separately from one another (Crenshaw, 1991). Therefore, therapy must aim to make not only clinical interventions aimed at shifting the couple dynamic, but also at making systemic changes that foster social justice for queer women. Queer women's intimate relationships are informed by how they navigate society and these negotiations ultimately inform how partners relate to one another. How partners negotiate power, privilege, and marginalization not just as individuals, but also intimately are key in transforming their relational experiences and ultimately the societal impact of oppression on their lives.

Using a multiracial feminist approach in session with June and Sydney, we began to identify ways in which societal forces related to various aspects of their identities influenced their conflict, allowing them to see themselves as a team, struggling against an issue instead of being opponents in arguments. For example, cohabitating out of necessity due to the increasing gentrification of Brooklyn is an external factor that changed their relationship early in their partnership. We worked in sessions to externalize this struggle, challenging the internalized narrative of being a "bad person" because they could not afford to live independently, or of moving in with one another too early in their relationship. As an interracial couple and a mixed orientation couple, ways in which racism and biphobia impacted them not only externally, such as June experiencing microaggressions at her job, but also internally were also highlighted. Sydney worked in session to expand her understanding of racial microaggressions that June experiences and how she could support her in those moments. Similarly, June reflected on ways that biphobia impacted Sydney, and explored ways she could comfort her when she experienced biphobia, both from their friends and at work.

Develop a Shared Language that Promotes Social Justice

Stories are a basic human strategy for processing fundamental elements of our experience, such as time, what happened, and change. This is not a new concept to therapy, as narrative therapy theory holds the same, asserting that knowledge is constructed through the way we make meanings of our experiences and story is the way in which we come to know things about ourselves (White & Epston, 1990). This is also echoed by indigenous feminist scholar Margaret Kovach who states that stories are not only knowing, but they situate us in relation to our world and our world in relation to us (Kovach, 2009). Furthermore, stories are never apolitical or acultural. Rather, they are woven in the story and culture and community must be understood in order to understand the story itself (Kovach, 2009). As therapists working with queer women couples, language is the smallest building block from which we can understand the cultures that come into session. Language is also the most basic intervention we can make toward social justice, by

using queer-affirming language and language that challenges hegemonic systems of oppression. Having explicit conversations about words like "normal" or "opposite sex" in session allows for interrogations of the ways heteronormativity restricts gender to a binary and creates an intersection of culture spaces in which queer women are constantly feeling "abnormal." For queer women couples to share their stories, there must be trust between the couple and therapist. Co-constructing a language in which everyone becomes an active player in defining the words used to describe relationship dynamics in session is one key way therapists can build this trust with queer women couples. Further, it builds on the strength that queer women couples already have—intentional communication. Communication for queer women couples is not something that they passively engaged in; rather, they name being deliberate about deeply talking to one another as a factor in maintaining their relationships (McEachern, 2020).

Developing a shared language around presenting concerns that affirmed them as a couple was another major task of therapy with Sydney and June. For example, when discussing wanting to be more sexually intimate, June would say "we don't have a fire anymore" and Sydney would similarly state "nothing is happening in the bedroom department." I (MM) reflected how both of these statements seemed loaded with expectations about what their sex life "should" look like and painted their intimacy as the issue. We explored the other factors, such as worry about finances, that seemed to "steal their fire," and even discussed ways that their fights hindered their sexual intimacy. In later sessions, we also discussed the various ways sex could look for them as a queer women couple. They started to use phrases like "we messed around," which spoke to some physical intimacy. Through reframing what sex looked like for them, the two used fewer negative problem-saturated phrases to describe their sex life. In one session, June stated, "we loved up on one another," noticing ways the two of them still had "fire" in their physical interactions. Over time, we discovered that the way the two of them described their relationship was also heavily informed by their perception of their familial support and connectedness as well. We not only identified the ways in which June's mom being supportive helped them through "rough patches," but also their sibling relationships and support from other family members. This emphasizes the ways in which a multiracial feminist approach addresses intergenerational buffers to societal oppression and also works with relationships beyond the therapy room.

Self of the Therapist

A multiracial feminist approach must also include the therapist gaining an understanding of their own biases and intersections of identities. Dee Watts-Jones (2010) states that location of self is a strategy therapists can use to open dialogue about identity and intersectionality in therapy. Specifically, she urges therapists to invite conversations about their own social identities as they relate to the experiences couples are struggling through in session. As therapists, we begin this conversation early and often with couples in sessions by sharing our identities with clients in intake sessions. This conversation in our experience is often met with relief from clients, who have sought out therapists who either share aspects of their identities, such as race, gender, or sexual orientation, or therapists who are willing to explicitly talk about identity as a force in their lived experiences.

June and Sydney shared in their second session that they sought out a queer woman therapist. Since these identities were important to them in establishing a therapeutic relationship, in my (MM) work with them, I was sure to name my identities and how interlocking systems of oppression inform my world view. We discussed the ways in which they saw me as a member of their community and also communities I did not share with them. This allowed for conversations around parts of their identities that they did not initially express as salient to them, such as their spiritual practices and religious communities. I was also sure to underscore differences

in our experiences in order to make room for possibilities the two of them may not have noticed in their relationship around their different social locations. Because queer social networks are small and the three of us lived in the same city, confidentiality was an ongoing conversation. We discussed ways we would navigate bumping into each other at events for queer women in the city, and how I would navigate having mutual friends with them. The particularity of my life as a Black queer woman was a source of support for them in therapy as I navigated difficulties similar to Sydney and June attempting to maintain relationships.

Therapists using a multiracial feminist lens should also deeply interrogate their own biases and values through engaging actively in self of the therapist work outside of session. We all live in culture that imparts explicit and implicit biases and messages around queerness and women and we must be aware of how we internalized those messages. Addison and Coolhart's (2015) relational intersectional lens for working with queer couples introduced strategies for working with couples experiencing oppression due to any aspect of their identity. The authors shift away from using unidimensional views of identity and outline an intersectional lens of identity, oppression, and power as complex and subjective (Addison & Coolhart, 2015). Addison and Coolhart (2015) state that this provides the possibility for action against oppression collectively—social justice—and connection over shared experiences between the clients, therapist, and each other.

Conclusion

We encourage therapists to use an intersectional feminist approach when working with queer women couples, understanding that their experiences of societal oppression and resilience are perceived through an intricate matrix of identities simultaneously. Women of color feminists provide key frameworks for this work and have informed all of our clinical work. Moreover, women of color feminists have allowed us to radically locate ourselves socially and as therapists, interrogating the systems of power and oppression we experience inside and outside of the therapy room. A multiracial feminist approach to therapy with queer women couples addresses multiple axes of identity and power and how they overlap for the couple, develops a shared language that affirms their relationship, and considers the therapist's identities and world views in the therapeutic process. A multiracial feminist approach to working with queer women couples does not require us as therapists to be experts on all of the ways privilege and oppression may intersect in the lives of queer women, but to be intensely curious about the numerous factors interacting in sessions. Having explicit conversations about identity and experiences with oppression is an integral part of remaining aware of the impact of intersectionality on their relationship and therapy sessions. This intentionality and curiosity to sameness and difference allows for a therapeutic process to develop that affirms queer women in all of their richness of relational experiences.

References

Addison, S., & Coolhart, D. (2009). Integrating socially segregated identities: Queer couples and the question of race. In M. Rastogi & V. Thomas (Eds.), *Multicultural couple therapy* (pp. 51–75). Sage. https://doi.org/10.4135/9781452275000.n4

Addison, S., & Coolhart, D. (2015). Expanding the therapy paradigm with queer couples: A relational intersectional lens. *Family Process, 54*(3), 435–453. https://doi.org/10.1111/famp.12171

Balsam, K. F., Molina, Y., Beadnell, B., Simoni, J., & Walters, K. (2011). Measuring multiple minority stress: The LGBT people of color microaggressions scale. *Cultural Diversity and Ethnic Minority Psychology, 17*(2), 163–174. https://doi.org/10.1037/a0023244

Balsam, K. F., & Szymanski, D. M. (2005). Relationship quality and domestic violence in women's same-sex relationships: The role of minority stress. *Psychology of Women Quarterly, 29*(3), 258–269. https://doi.org/10.1111/j.1471-6402.2005.00220.x

Battle, J., & Harris, A. (2013). Belonging and acceptance: Examining the correlates of sociopolitical involvement among bisexual and lesbian Latinas. *Journal of Gay & Lesbian Social Services, 25*(2), 141–157. https://doi.org/10.1080/10538720.2013.782520

Biaggio, M., Coan, S., & Adams, W. (2002). Couples therapy for lesbians. *Journal of Lesbian Studies, 6*(1), 129–138. https://doi.org/10.1300/J155v06n01_12

Bigner, J. J. (2000). Gay and lesbian families. In W. C. Nichols, M. S. Pace-Nichols, D. S. Becvar, & A. Y. Napier (Eds.), *Handbook of family development and intervention* (pp. 279–298). Wiley.

Bowleg, L., Huang, J., Brooks, K., Black, A., & Burkholder, G. (2003). Triple jeopardy and beyond: Multiple minority stress and resilience among Black lesbians. *Journal of Lesbian Studies, 7*(4), 87–108. https://doi.org/10.1300/J155v07n04_06

Brooks, S. (2016). Staying in the hood: Black lesbian and transgender women and identity management in North Philadelphia. *Journal of Homosexuality, 63*(12), 1573–1593. https://doi.org/10.1080/00918369.2016.1158008

Brown, L. S. (1995). Therapy with same-sex couples: An introduction. In N. S. Jacobson & A. S. Gurman (Eds.), *Clinical handbook of couple therapy* (pp. 274–291). Guilford.

Bryant, A. S., & Demian. (1994). Relationship characteristics of American gay and lesbian couples: Findings from a national survey. *Journal of Gay and Lesbian Social Services, 1*(2), 101–117. https://doi.org/10.1300/J041v01n02_06

Collins, P. H. (2000). Gender, black feminism, and black political economy. *The Annals of the American Academy of Political and Social Science, 568*(1), 41–53. https://doi.org/10.1177/000271620056800105

Connolly, C. M. (2004). Clinical issues with queer couples: A review of the literature. In J. J. Bigner & J. L. Wetchler (Eds.), *Relationship therapy with queer couples* (pp. 3–12). Haworth. https://doi.org/10.1300/J398v03n02_02

Connolly, C. M. (2012). Lesbian couple therapy. In J. J. Bigner & J. L. Wetchler (Eds.), *Handbook of LGBT-affirmative couple and family therapy* (pp. 43–56). Routledge.

Connolly, C. M., & Sicola, M. K. (2005). Listening to lesbian couples: Communication competence in long-term relationships. *Journal of GLBT Family Studies: Innovations in Theory, Research, and Practice, 1*(2), 143–167. https://doi.org/10.1300/J461v01n02_09

Crenshaw, K. (1991). Race, gender, and sexual harassment. *Southern California Law Review, 65*, 1467.

Glass, V. Q. (2014). "We are with family": Black lesbian couples negotiate rituals with extended families. *Journal of GLBT Family Studies, 10*(1–2), 79–100. https://doi.org/10.1080/1550428X.2014.857242

Glass, V. Q., & Few-Demo, A. L. (2013). Complexities of informal social support arrangements for Black lesbian couples. *Family Relations, 62*(5), 714–726. https://doi.org/10.1111/fare.12036

Green, M. S., Murphy, M. J., Blumer, M., & Palmanteer, D. (2009). Marriage and family therapists' comfort level working with gay and lesbian individuals, couples, and families. *The American Journal of Family Therapy, 37*(2), 159–168. https://doi.org/10.1080/01926180701441429

Green, R. -J. (2000). "Lesbians, gay men, and their parents": A critique of LaSala and the prevailing clinical "wisdom." *Family Process, 39*(2), 257–266. https://doi.org/10.1111/j.1545-5300.2000.39208.x

Green, R. -J. (2002). Lesbians, gays, and family psychology: Resources for teaching and practice. In E. Davis-Russell (Ed.), *The California school of professional psychology handbook of multicultural education, research, intervention, and training* (pp. 88–105). Jossey-Bass.

Green, R. -J., Bettinger, M., & Zacks, E. (1996). Are lesbian couples fused and gay male couples disengaged?: Questioning gender straightjackets. In J. Laird & R. -J. Green (Eds.), *Lesbians and gays in couples and families: A handbook for therapists* (pp. 185–230). Jossey-Bass.

Green, R. -J., & Mitchell, V. (2015). Gay, lesbian, and bisexual issues in couple therapy. In A. S. Gurman, J. L. Lebow, & D. K. Snyder (Eds.), *Clinical handbook of couple therapy* (5th ed., pp. 489–511). Guilford.

Greenan, D. E., & Tunnell, G. (2003). *Couple therapy with gay men.* Guilford.

Greene, B. (1994). Lesbian women of color: Triple jeopardy. In L. Comas-Diaz & B. Greene (Eds.), *Women of color: Integrating ethnic and gender identities in psychotherapy* (pp. 389–427). Guilford.

Hartwell, E. E., Serovich, J. M., Reed, S. J., Boisvert, D., & Falbo, T. (2017). A systematic review of gay, lesbian, and bisexual research samples in couple and family therapy journals. *Journal of Marital and Family Therapy, 43*(3), 482–501. https://doi.org/10.1111/jmft.12220

Henke, T., Carlson, T. S., & McGeorge, C. R. (2009). Homophobia and clinical competency: An exploration of couple and family therapists' beliefs. *Journal of Couple & Relationship Therapy, 8*(4), 325–342. https://doi.org/10.1080/15332690903246101

Hernández, P., & Rankin, IV, P. (2008). Relational safety and liberating training spaces: An application with a focus on sexual orientation issues. *Journal of Marital and Family Therapy, 34*(2), 251–264. https://doi.org/10.1111/j.1752-0606.2008.00067.x

Kovach, M. (2009). *Indigenous methodologies: Characteristics, conversations, and contexts*. University of Toronto Press.

Kurdek, L. A. (2008). Change in relationship quality for partners from lesbian, gay male, and heterosexual couples. *Journal of Family Psychology, 22*(5), 701–711. https://doi.org/10.1037/0893-3200.22.5.701

Lang, M. (2017, February 13). Why lesbian dating apps have failed to connect. https://www.sfchronicle.com/business/article/Why-lesbian-dating-apps-have-failed-to-connect-10924704.php

Lehavot, K., & Simoni, J. M. (2011). The impact of minority stress on mental health and substance use among sexual minority women. *Journal of Consulting and Clinical Psychology, 79*(2), 159–170. https://doi.org/10.1037/a0022839

Lorde, A. (2007). *Sister outsider: Essays and speeches.* Crown Publishing Group.

Lorde, A. (2017). Age, race, class, and sex: Women redefining difference. In B. K. Scott, S. E. Cayleff, A. Donadey, & I. Lara (Eds.), *Women in culture: An intersectional anthology for gender and women's studies* (2nd ed., pp. 16–22). Wiley.

McEachern, M. (2020). *Revolutionships: Experiences of queer women of color maintaining romantic relationships while engaging in contemporary movements for liberation* [Doctoral dissertation]. Syracuse University.

McGeorge, C. R., & Carlson, T. S. (2010). Social justice mentoring: Preparing family therapists for social justice advocacy work. *Michigan Family Review, 14*(1), 42–59. https://doi.org/10.3998/mfr.4919087.0014.106

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129*(5), 674–697. https://doi.org/10.1037/0033-2909.129.5.674

Ossana, S. M. (2000). *Relationship and couples counseling.* In R. M. Perez, K. A. DeBord, & K. J. Bieschke (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients* (pp. 275–302). American Psychological Association. https://doi.org/10.1037/10339-012

Otis, M. D., Riggle, E. D., & Rostosky, S. S. (2006). Impact of mental health on perceptions of relationship satisfaction and quality among female same-sex couples. *Journal of Lesbian Studies, 10*(1/2), 267–283. https://doi.org/10.1300/J155v10n01_14

Otis, M. D., Rotosky, S. S., Riggle, E. D. B., & Hamrin, R. (2006). Stress and relationship quality in queer couples. *Journal of Social and Personal Relationships, 23*(1), 81–99. https://doi.org/10.1177/0265407506060179

Riggle, E. D., Rostosky, S. S., & Horne, S. G. (2010). Psychological distress, well-being, and legal recognition in same-sex couple relationships. *Journal of Family Psychology, 24*(1), 82–86. https://doi.org/10.1037/a0017942

Ritter, K. Y., & Terndrup, A. I. (2002). *Handbook of affirmative psychotherapy with lesbians and gay men*. Guilford.

Scrivner, R., & Eldridge, N. S. (1995). *Lesbian and gay family psychology.* In R. H. Mikesell, D. D. Lusterman, & S. H. McDaniel (Eds.), *Integrating family therapy: Handbook of family psychology and systems theory* (pp. 327–345). American Psychological Association. https://doi.org/10.1037/10172-018

Sharf, R. S. (2008). *Theories of psychotherapy and counseling.* Brooks/Cole.

Singh, A., & Chun, K. Y. S. (2010). "From the margins to the center": Moving towards a resilience-based model of supervision for queer people of color supervisors. *Training and Education in Professional Psychology, 4*(1), 36–46. https://doi.org/10.1037/a0017373

Szymanski, D. M., & Chung, Y. B. (2001). The lesbian internalized homophobia scale: A relational/theoretical approach. *Journal of Homosexuality, 41*(2), 37–52. https://doi.org/10.1300/J082v41n02_03

Szymanski, D. M., Chung, Y. B., & Balsam, K. F. (2001). Psychosocial correlates of internalized homophobia in lesbians. *Measurement and Evaluation in Counseling and Development, 34*(1), 27–38. https://doi.org/10.1080/07481756.2001.12069020

Taylor, S. E., Klein, L. C., Lewis, B. P., Gruenewald, T. L., Gurung, R. A. R., & Updegraff, J. A. (2000). Behavioral responses to stress in females: Tend-and-befriend, not fight-or-flight. *Psychological Review, 107*(3), 411–429. https://doi.org/10.1037/0033-295X.107.3.411

The Combahee River Collective. (2014). A black feminist statement. *Women's Studies Quarterly, 42*(3/4), 271–280. https://doi.org/10.1353/wsq.2014.0052

Watts-Jones, T. D. (2010). Location of self: Opening the door to dialogue on intersectionality in the therapy process. *Family Process, 49*(3), 405–420. https://doi.org/10.1111/j.1545-5300.2010.01330.x

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends.* Norton.

Wilson, B. D., Okwu, C., & Mills, S. A. (2011). Brief report: The relationship between multiple forms of oppression and subjective health among Black lesbian and bisexual women. *Journal of Lesbian Studies, 15*(1), 15–24. https://doi.org/10.1080/10894160.2010.508393

Zinn, M. B., & Dill, B. T. (1996). Theorizing difference from multiracial feminism. *Feminist Studies, 22*(2), 321–331. https://doi.org/10.2307/3178416

6
"There's a Lot We Don't Understand About Each Other"
Centering Bisexual Partners in Couple Therapy

ERICA E. HARTWELL, KATIE M. HEIDEN-ROOTES and STEPH COOKE

In order to work with bisexual individuals and their partners, therapists need to understand the assumptions and social forces that create the context in which these relationships are formed. In this chapter, we create a framework for evidence-based practice (American Psychological Association, 2005) that is an integration of the best available research, our clinical experience and expertise, and the sociocultural context of bisexual relationships. Although intimate relationships serve as a protective factor for most people, this is not always the case for bisexual individuals (Feinstein et al., 2016), who frequently partner with people who are gay, lesbian, or heterosexual, and may have stigmatizing beliefs about bisexuality.

When we refer to bisexual couples or bisexual relationships, we mean any intimate relationship of two or more people in which at least one identifies as bisexual or experiences attraction to more than one gender. These relationships could take any number of forms. Most commonly seen is a couple in which one partner is bisexual and the other is gay, lesbian, or straight. Although less common, the other partner could also be bisexual or, even less frequently, asexual. In consensual non-monogamous relationships (e.g. polyamorous, open), there could be any combination of orientations, identities, or attractions. In all of these situations, if at least one person identifies as bisexual or experiences attraction to more than one gender, we will refer to them as a bisexual couple or relationship. Lastly, the research, clinical expertise, and sociocultural framework presented in this chapter are situated within the Western world, particularly the United States.

What Is Bisexuality?

The term bisexuality has been criticized for reinforcing gender and sexual binaries and for excluding transgender and nonbinary individuals (Eisner, 2013). It is true that the prefix "bi" comes from the Latin word for "two" and this often leads people to define bisexuality as attraction to "both" genders. To be sure, if we define bisexuality this way, it does affirm a sex and gender binary and does exclude those who do not identify exclusively as male or female. However, for many, bisexuality means being attracted to people of genders similar to one's own and to people of genders different from one's own. This understanding of bisexuality subverts the gender binary because this includes cisgender men and women, transgender men and women, and non-binary individuals. Furthermore, bisexuality as a sexual orientation is not exclusive to cisgender men and women; transgender men and women can and do identify as bisexual (Alexander & Yescavage, 2003).

We consider bisexuality to be synonymous with *plurisexuality*, which is often used in contrast to *monosexuality*, or attraction to only one gender. People who are monosexual may be attracted to someone of the same gender and use labels like gay or lesbian or may be attracted to people of

DOI: 10.4324/9780429274626-9

a different gender and use labels like straight or heterosexual. People who are plurisexual may also use a variety of labels to describe their attraction, such as bisexual, pansexual, or queer. Bisexual activist Robyn Ochs defines bisexuality as "the potential to be attracted—romantically and/or sexually—to people of more than one sex or gender, not necessarily at the same time, not necessarily in the same way, and not necessarily to the same degree" (Eisner, 2013, p. 21). In this chapter, we use the term bisexual to include all those who experience attraction to genders similar to and different from their own, knowing that there are many ways one might label this attraction differently.

Prevalence of Bisexuality

Bisexual-identified individuals make up an estimated 1.8% of the United States population, which is slightly higher than lesbian and gay-identified individuals at 1.7% (Gates, 2011). However, it is likely that bisexuality is more prevalent than survey data indicate due to the many barriers to measuring it (Fairyington, 2008). There can be discrepancies between how the researcher defines bisexuality and how the individual defines bisexuality. For example, many studies include participants who identify as mostly lesbian or gay, but still engage in bisexual behavior (Rust, 1999). Many people may fit our definition of bisexuality, but do not choose that label for themselves and so would not select that option if it were provided on a survey. A more inclusive measure might contain questions about sexual and romantic behaviors and attraction; even in this situation, responses may be limited to certain time periods and, therefore, not capturing someone's sexuality over a lifetime. Because of these complexities, researchers may avoid including bisexual participants in studies or may exclude these participants from data analysis, which results in a lack of scholarship focused on bisexuality and an inaccurate measure of who is bisexual.

Research indicates that women are more likely than men to identify as bisexual. In Gates' (2011) review of nine national and international surveys, bisexual identities made up more than half (from 55% to 62%) of the lesbian and bisexual women surveyed. The converse was true for men where over two-thirds reported a gay identity (from 56% to 67%).

Coming Out and Identifying as Bisexual

Coming out can be particularly complicated for bisexual individuals due to *monosexism*. Previously, we defined monosexuality as attraction to people of one gender. Monosexism is a cultural assumption that everyone is attracted to only one gender and that this type of attraction is more valid, valued, and normal than attraction to more than one gender. Therefore, bisexuality is often not seen as a valid sexual orientation, which can be confusing and distressing for someone experiencing attraction to multiple genders. They may dismiss or deny some of their attractions and adopt a monosexual label, such as gay or straight. They may come out privately to themselves, acknowledging all of their attractions, but not share with others. Unlike monosexual people, a bisexual person's identity is not made visible by their relationship. Others often assume sexual orientation based on the gender of one's partner. For example, if a bisexual person is dating someone of a different gender, they will be seen as straight until they tell people otherwise. If they are dating someone of the same gender, they will be seen as gay or lesbian until they come out otherwise. Monosexism complicates the coming out process for bisexual individuals, adding additional considerations above those of gay and lesbian persons. To illustrate this, we describe two case studies and two empirically based identity development models.

One of the first models of bisexual identity development was based on data collected over six years at the Bisexual Center in San Francisco (Weinberg et al., 1994). The model included four linear stages: (a) initial confusion; (b) finding and applying the label; (c) settling into the identity; and (d) continued uncertainty. The fourth stage, continued uncertainty, was based on

participants reporting that they continued to define, redefine, and struggle with their bisexual identity years after adopting the label. This uncertainty stemmed largely from their relationships with others—partners, family, friends—and how they responded to the bisexual identity. In his review of bisexual identity development models, Brown (2002) relabeled this fourth stage as identity maintenance because most participants (75%) in Weinberg et al.'s (1994) study continued to label as bisexual despite occasional uncertainty. Brown highlighted that most of the uncertainty reported in the 1994 study was due to social invalidation, lack of bisexual community and role models, and being in a long-term monogamous relationship. The last factor is illustrated in the case of Josué and David:

> Josué (cisgender, Mexican-American) has known he was bisexual since he was a teenager. He dated people of different genders from adolescence right up until he met David (cisgender, gay, Puerto Rican), who he has been with for six years. David often asks, "why do you insist on calling yourself bisexual? You've been with me for years. All of our friends are gay. It just seems easier if you say you're gay." Josué explains to his therapist, "I wonder whether bisexual fits for me anymore. I want to be with David for the rest of my life…but I am pretty sure I could be with a woman if David and I broke up. Sometimes it's easier to just say 'gay,' but it also doesn't feel quite right."

In the same year that Weinberg et al. published their four-stage model, D'Augelli (1994) published a model based on data collected from lesbian, gay, and bisexual (LGB) youth that included six discrete, potentially concurrent, non-consecutive identity processes: (a) exiting heterosexuality; (b) developing a personal LGB identity; (c) developing an LGB social identity; (d) becoming an LGB offspring; (e) developing LGB intimacy status; and (f) entering an LGB community. The benefit of a task-oriented model is that it does not require individuals to progress from one stage to another and does not describe revisiting a particular stage as regressive or problematic. The challenge with this model is that it includes lesbian and gay individuals, whose experiences differ from bisexual individuals in distinct ways. However, the six tasks can be modified to center the bisexual experience and provide a helpful framework for understanding identity development processes: (a) exiting monosexuality; (b) developing a private bisexual description; (c) developing a public bisexual description; (d) becoming a bisexual offspring; (e) exploring fluidity of attraction and behavior; and (f) engaging with bisexual community (RichardsFink, 2014). The benefit of a process-oriented model is that each task is defined but not required. That is, a bisexual person who experiences their identity as static may not find it meaningful to explore the fluidity of their attraction or behavior. For those who do experience fluidity, this particular task may be inextricably linked to their intimate relationships:

> Jennifer (white, lesbian, transwoman) and Amy (Chinese-American, bisexual, cisgender) have been married for 12 years and have two young children. Jennifer disclosed her gender identity to Amy and began her transition five years ago. Amy shares, "I had always considered myself straight. I was attracted to men and had only dated men. When Jennifer started to transition, we were both scared that it would change the way I felt about her. Fortunately, it didn't. But it did change the way I thought about myself. I don't think I could be with any other woman than Jennifer, so 'lesbian' doesn't feel right…but neither does straight! So, I have come to consider myself 'bisexual.'"

In both models, the availability of social support is critical to resolving several stages or tasks. Because bisexuality is less visible and less frequently discussed as a valid identity, it may take bisexual people longer to resolve confusion, exit monosexuality, find and apply the label, or develop private bisexual descriptions. Because there are few visible bisexual communities, a bisexual person trying to settle into their identity, develop a public description, or engage with a

bisexual community may look for other bisexual peers but not find many. They may be left trying to fit into either straight or gay/lesbian culture or isolating from both. It may be harder for bisexual individuals to maintain their identities and engage in both intimate and social relationships as a bisexual person, as they risk rejection from both straight and gay/lesbian communities (Balsam & Mohr, 2007). Therefore, the development of a bisexual identity may depend as much on the acceptance and validation of important others as it does on the individual's own self-acceptance.

The Sociocultural Context for Bisexuality and Biphobia

Above, we have provided a definition of bisexuality—attraction to genders similar to and different from one's own—that is based on research, bisexual literature, and our own personal understanding. However, these sources and interpretations are based on a larger sociocultural framework that we must be aware of in order to understand the root of bisexual stigma. The fact that bisexuality has been defined, misunderstood, and redefined is due to overarching societal norms that create and reinforce bisexual stigma.

Gender Binary

Perhaps the most pervasive of these societal norms is the gender binary system. The gender binary is a social construct that encompasses biological sex, gender identity, gender expression, and attraction. It is a powerful discourse that operates in the background of our daily lives and is at the source of sexual and gender-based prejudice. The gender binary is a classification of gender into two distinct and opposite categories: masculine and feminine. It also assumes that one's gender is inherently connected to one's sexual characteristics, to one's gender expression, and to one's sexual or romantic attraction (Figure 6.1). The gender binary tells us, for example, that if we determine a person's biological sex at birth to be male, then that person will identify as a man, will express his gender in a masculine way (according to social norms), and will be exclusively attracted to women.

There are socially sanctioned—but often unspoken—rules to the gender binary system and consequences for those who break them. First, a person is assumed be on one side or the other; not neither, not both, not a combination. That is, if a person's sex is determined to be female, they are expected to identify as a woman, express themself in a feminine way, and be exclusively attracted to people who identify as men (and express themselves in a masculine way and are exclusively attracted to people who identify as women). There are many ways that people do not fall into these two strict binaries, including transgender individuals, nonbinary people, or

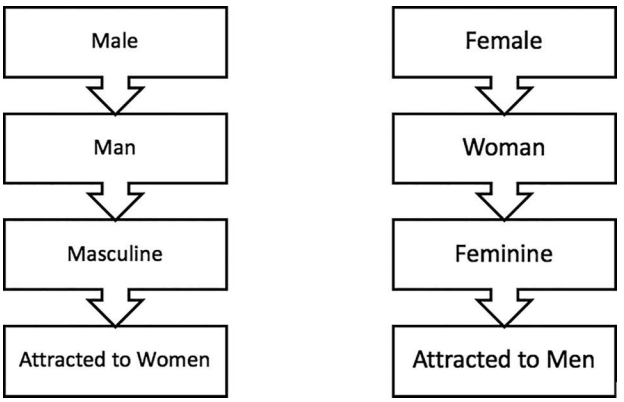


Figure 6.1 Gender binary system

those attracted to people of the same gender. Bisexual people break this rule by not experiencing attraction exclusively to one sex or gender.

The second rule of the gender binary system is that gender is necessarily incontrovertibly connected to biological sex, which is assigned at birth and based on the assumption that there are two and only two options for sex and gender. Typically, a medical professional determines the sex of a baby by viewing the child's genitalia, and once assigned, a pre-ordained pathway of gender roles, personality traits, and corresponding life choices are encouraged and reinforced by everyone from caregivers to teachers to peers. Intersex individuals challenge the notion of a gender binary as they have both male and female sex characteristics. Many children, intersex or not, are taught to identify with and express themselves within narrow definitions of gender—everything from toys and clothes to expressions of love and emotion are defined according to the gender binary. In some ways, bisexual individuals break this rule as they are seen as being unable to choose between two "sides" or two genders.

The third rule of the gender binary is that the male half has more value than the female half because of the patriarchal and misogynist values that structure the United States and much of the Western world. Because men and masculine expressions are seen as more valuable than women and feminine expressions, those who cross the gender binary from man to woman typically face more severe consequences. For example, transgender women (i.e. individuals born with primarily male sex characteristics who identify as women)—especially transgender women of color—are victimized and murdered at higher rates than any other group (Griffin, 2016). In addition, there is more hostile and reactive homophobia toward cisgender gay men than cisgender lesbians, particularly those who express their gender in a more androgynous or feminine way. This rule partially accounts for the differing societal views toward bisexual men and bisexual women. Being attracted to women has social rewards (as it is seen as a masculine trait in the binary), whereas being attracted to men is devalued (as it is seen as a feminine trait). Therefore, bisexual men who are attracted to other men may experience more discrimination and rejection than bisexual women who are attracted to other women. Of course, this is not always the case and there are many ways that bisexual women's sexuality is marginalized (discussed in more detail below).

The gender binary system creates and reinforces many of the social constructs that maintain gender and sexuality-based prejudice and oppression, including, *heteronormativity*, *cisnormativity*, *mononormativity,* and even *white supremacy*. The first three are widespread beliefs that heterosexuality is the default or normal sexual orientation (Warner, 1991), that biological sex is the sole determinant of gender identity and expression (Worthen, 2016), and that the only legitimate relationships are between two monogamous partners (Pieper & Bauer, 2005). White supremacy is an ideology and a sociopolitical system that provides structural advantages to white people and maintains their dominance over other racial and ethnic groups (Flint, 2004). White supremacy and the gender binary are inextricable from one another, as white supremacy upholds heterosexuality and masculinity as ideal. European colonizers targeted and attempted to eradicate the sexual and gender diversity that existed in each indigenous society they encountered (Morgensen, 2011). The gender binary sets the stage for another sociocultural phenomenon that greatly impacts the well-being of bisexuals, known as *bisexual erasure*.

Bisexual Erasure

Bisexual erasure is a "social contract" to ignore, remove, falsify, or re-explain evidence of bisexuality in history, academia, news media, fiction, and personal lives (Yoshino, 2000, p. 353). Erasure occurs on three different levels: class erasure, individual erasure, and delegitimization. Class erasure is the belief that bisexuality is not a real sexual orientation; for example, a person's sexual orientation is assumed based on the gender of their partner instead of considering that they may be attracted to multiple genders. Individual erasure occurs when bisexuality is

accepted as a real orientation but an individual is not allowed to identify as such. An example is when a bisexual person is asked to prove their sexual identity by demonstrating that they have had a certain number of romantic or sexual relationships with people of different genders. Finally, delegitimization occurs when bisexuality is accepted as real and an individual is accepted as a real bisexual, but they are then stigmatized or maligned for that identity. Examples include labeling bisexual people as promiscuous, greedy, traitors, unreliable, or unfaithful.

Both straight and gay/lesbian people participate in bisexual erasure, in a phenomenon that Robyn Ochs (1996) described as double discrimination. However, it is important to note these groups cannot be considered equally oppressive. Gay and lesbian communities may collaborate in the oppression of bisexual people, but they are also operating within and being oppressed by a powerful paradigm, heteronormativity. According to Yoshino (2000), straight and gay communities are invested in bisexual erasure for three reasons: (a) to stabilize sexual orientation; (b) to retain the primacy of sex and gender; and (c) to preserve the norms of monogamy. Each of these reasons stems from and supports the gender binary system. First, bisexuality questions the idea of monosexuality—that people are only attracted to one gender. Straight people maintain heterosexual privilege through their attractions to and relationships with someone of a different gender. Through this, they can demonstrate that they are not gay. They cannot prove, however, that they are not bisexual. Bisexuality also threatens the argument that gay and lesbian people are born that way and cannot change; this rhetoric has been crucial to gaining cultural support and civil rights, and bisexuality can be used to refute this argument. Second, bisexuality undermines the notion of binary sexes that are opposite and exclusive categories around which our relational experiences are organized. Straight cisgender men and women tend to form same-gender friend groups and engage with different-gender peers only for romantic or sexual reasons. Gay and lesbian communities are often organized by gender as well, with each group meeting all platonic, sexual, and romantic needs. Bisexuality introduces the possibility of crossing between and among these segregated spheres. Finally, bisexuality threatens monogamy by taking away an assumed certainty about to whom one's partner could or could not be sexually attracted. For both straight and gay partners, this insecurity can lead to stigmatizing or rejection of bisexual partners.

Bisexual erasure is a product of the gender binary system which reinforces other oppressive paradigms such as heteronormativity and patriarchy. However, we are each responsible for examining our assumptions and recognizing the impact that erasure has on the mental health and well-being of bisexual people. Class erasure, individual erasure, and delegitimization hinder the articulation of a bisexual identity at every stage of development, perpetuating the cycle of invisibility, misconceptions, and stigma. In the next section, we discuss the impact of this stigma on mental health.

Minority Stress

Dominant discourses (e.g. gender binary, heteronormativity) are experienced by individual people as minority stressors. Minority stress for LGB individuals can include distal stressors, such as discrimination, rejection, or violence, and proximal stressors, such as expectations of rejection, internalized homo/biphobia, and deciding how, when, and to whom to come out (Meyer, 2003). Meyer's minority stress model describes how these stressors can lead to negative health outcomes. Meyer also suggested that the effect of minority stress on mental health could be mitigated with coping skills and social support from romantic partners, family, friendships, and the LGB community.

The effects of minority stress on mental health outcomes, such as depression and substance abuse, have consistently been demonstrated for LGB samples as have the protective influences of support from family and friends. However, Meyer himself (2003) noted that many research studies do not distinguish bisexual participants from gay and lesbian participants, which means

that we have minimal data on the unique stressors and prevalence of mental health problems for bisexual individuals. We do know that bisexual individuals are significantly more likely to experience mood or anxiety disorders (Bostwick et al., 2010), eating disorders (Koh & Ross, 2006), substance use problems (Feinstein & Dyar, 2017), and suicidality (Brennan et al., 2010; Steele et al., 2009) than gay and lesbian individuals. As for the protective influences of social support, it is unclear how much support is available from the wider queer community for bisexual people (Balsam & Mohr, 2007) and whether social support can buffer the effect of stressors on their mental health (Feinstein et al., 2017).

In the context of couples, intimate partner violence is a significant minority stressor for bisexual individuals. Bisexual individuals experience more IPV than monosexual individuals, regardless of gender or race. Bisexual men experience IPV at higher rates (47%) than gay (25.2%) or heterosexual men (28.7%; Walters et al., 2013). Bisexual people of color report higher rates of violence than their white peers (Turrell et al., 2018; Whitton et al., 2019). However, bisexual women are more likely to experience IPV than any other person based on sexual orientation and gender of partner. Bisexual women are 2.6 times more likely than heterosexual women to experience IPV and more than half (56.9%) will at some point in their lives (Walters et al., 2013). Because transgender individuals also experience higher rates of IPV than cisgender people, with reports ranging from 31.1% to 50% (Brown & Herman, 2015), it is likely that bisexual transgender people of color are at the highest risk of violence. While IPV may not always be a presenting concern for couples, it is certainly a risk factor for bisexual couples and should be assessed for carefully and routinely.

Intersections of Minority Stress The term *intersectionality* was introduced in the 1980s to address interlocking identities (e.g. race, gender, class, sexuality, religion, and nationality, etc.) in the context of antidiscrimination and social justice (Cho et al., 2013). Although identities like race, gender, or sexual orientation are often discussed in isolation, they overlap and intertwine, creating unique experiences of privilege and oppression for each person depending on their context. Individuals with marginalized identities are more aware of power differences and how parts of their identity might carry privilege or oppression depending on the context. For example, a bisexual woman of color is aware of white supremacy, patriarchy, and biphobia. Depending on the context, one identity may be more salient than the other. If she is with her church community, her racial and spiritual identity may be important, while her bisexual identity is suppressed or oppressed. Similarly, when she is with her LGBTQ community, her bisexual identity may be more visible. However, she may also experience racism, sexism, and biphobia. Each person's experience of their identities will vary based on their social context.

As couple and family therapists, it is our mission to consider the context of our clients' lives. It is important to know how clients navigate personal and relational systems where they might feel isolated or experience distress. A key point for clinicians to remember when working with a variety of groups is that we are in a position of power by having the skills to facilitate change, therefore we have to be an effective resource for clients. Even clinicians who share a marginalized identity with a client must be careful not to project their experience onto the client, and to be curious and open to each person's intersectional identity. Regardless of one's identity, clinicians must be aware of the impact of power on clients' lives.

Common Issues in Couple Therapy with Bisexual Partners

The research is inconsistent about the degree of support available to bisexual individuals through their intimate couple relationships (Feinstein et al., 2016) or the larger queer community (Balsam & Mohr, 2007; Feinstein et al., 2017). As a result, couple dynamics may mimic cultural discourses of biphobia with violent and negative consequences; however, the couple

may also act in opposition to biphobia by offering a positive and open stance to the co-creation of a mutually satisfying relationship. Clinicians can expect bisexual couples or relationships to present with concerns similar to straight, gay, or lesbian couples. However, it is important to consider how the gender binary and bisexual erasure impact these relationships. In this section, we present three case studies that highlight the common issues that arise in couple therapy with bisexual partners: disclosure of bisexuality identity, sex, mixed orientations, consensual non-monogamy (CNM), parenting, and divorce.

June and Ben: Disclosing a Bisexual Identity

Coming out is a unique aspect of forming and maintaining intimate relationships for bisexual individuals as bisexual people are often in relationship with straight, gay, or lesbian partners. Because of bisexual erasure, partners often assume that the bisexual person shares the same sexual identity as them, necessitating that the bisexual partner come out (Bradford, 2006). This coming out can occur at any point in the relationship, from the first conversation to many years in, and may be met with a variety of responses. Ideally, partners will respond with understanding, curiosity, and acceptance. However, they may respond with biphobic comments or questions (Balsam & Mohr, 2007; Koh & Ross, 2006) or even end the relationship (Bowling et al., 2018).

The partner's negative response to coming out contributes to the difficulties in creating and sustaining intimate relationships for bisexual individuals (Klesse, 2011; Li et al., 2013). Bisexual men, in one small qualitative study, were more insistent about the need for acceptance from their partners than bisexual women (Bowling et al., 2018). This may reflect the intersection of masculinity and homophobia experienced most acutely for bisexual men (Bradford, 2006), who are often erased by being told that they must actually be gay. Bisexual women experience the converse, in which they are assumed to be straight and often experience rejection in the lesbian community (Li et al., 2013). In both of these examples, the bisexual person is assumed to prefer relationships with men, which highlights bisexual.

The timing of coming out in a relationship is a significant factor. Outcomes may be better when a bisexual partner comes out at the beginning of a relationship. The other partner can either end the relationship before a significant commitment has been made or they can integrate this new information while they are still getting to know their partner. When a partner comes out as bisexual later in a relationship, this can bring "confusion about the meaning of this awareness, conflicts (intrapersonal and interrelational) over the form that its exploration will take, and fear of a threat to the stability of the relationship" (Bradford, 2006, p. 45). The following case illustrates how this fear can present itself when a partner comes out as bisexual later in a relationship:

> June (a white, bisexual cis-woman) and Ben (a white, heterosexual cis-man) came to couple therapy 10 years into their marriage. Ben expressed he was confused and scared of what it meant now that June was "declaring herself a bisexual." He wondered if this meant he would have to accept being in an open marriage or worry that his partner would leave him for a woman. June responded with reassurance that this was not her intent and she had seen herself as bisexual since fourth grade when she had a crush on her best girl friend. Ben seemed shocked and said he was hurt that she had known for so long and not told him.
>
> The therapist asked June what messages she received about sexuality growing up. June explained, "my parents were very conservative, and we belonged to a fundamentalist church where being gay was about the worst thing you could do. When I realized I had feelings for Amy, I was terrified that I was bad, that my parents would find out and send me away, so I buried the feelings. I dated men because I liked men but also because I couldn't see another option. I didn't even know what bisexuality was until I was in college. Then I started to understand myself a little more."

Ben softened and said, "I know how judgmental your parents can be so it makes sense that you would hide this part of yourself. I also didn't know what bisexuality was until you brought it up a couple of years ago. So, I really don't know much about it or what it means to you. I just know I am scared that it means you will leave me." June reached for his hand and smiled, "No, Ben, I don't want to leave you."

In this case, the clinician had an understanding of how bisexuality is often erased and stigmatized and wondered how this had affected June's coming out process, both to herself and to other people in her life. As June told the therapist about her parents' conservative religious values, Ben was able to empathize with how her sexuality must have felt scary to her at a young age. The therapist can continue this dialogue to further unpack the ways that June has felt invisible in her bisexuality and what it means to her now in her relationship with Ben. Of course, not all partners will respond with empathy. Some may respond with anger, disgust, or even violence.

June and Ben's therapist may also want to assess their sexual relationship. Bisexual men and women are often hypersexualized and objectified by their male partners (Flanders & Hatfield, 2013). The presumption of bisexual promiscuity may create expectations and issues surrounding frequency of sex, relationship boundaries, and sexual activities. This is particularly salient in relationships between heterosexual men and bisexual women, where the female partner's sexuality may be seen as performative or entertainment to the male partner. The couple may establish an open relationship in which a second female sexual partner is included. If the bisexual partner's identity is not fully understood or acknowledged by the other partner, there can be discrepancies in each partner's expectations about sexual interactions with the third person. For example, if June and Ben decided to have sex with another woman, Ben might expect that the two women will be focused on him, while June may expect to have one-on-one time with the other woman so that she can explore that part of her sexuality. If these expectations are not discussed explicitly, they can lead to hurt feelings, anger, and rejection during and after the sexual encounter.

Although sexual concerns are common in couples and in couple therapy, there is very little research on sexual scripts and problems faced by bisexual individuals (Gauvin & Pukall, 2018). Only two studies have examined sexual concerns for bisexual individuals. Both studies focused on sexual pain and found that lesbian and bisexual women reported higher sexual functioning than heterosexual women (Blair et al., 2015; Breyer et al., 2010). Blair et al. (2015) speculated that bisexual women who had same-gender sexual experiences were able to broaden their sexual scripts and, as a result, experience fewer sexual problems because of their experience communicating about sexual pleasure and desire beyond traditional, patriarchal notions of penile-vaginal intercourse. However, some bisexual individuals may be hesitant to broaden sexual scripts with their partners for fear of a biphobic reaction (e.g. "you're a slut," or "you really want to be with a woman"). As with any couple, therapists can explore the sexual scripts, desires, and expectations of each partner and empower each of them to choose what is right for them, not what they have been taught by larger societal discourse.

Emily and Kiara: Consensual Non-Monogamy

As discussed above, bisexual individuals are often in relationships with partners who identify as straight, gay, or lesbian. They are more likely to be in a different-gender relationship than a same-gender relationship—60% compared to 4% according to one study (Gates, 2014)—and in either relationship, their sexual orientation is incorrectly assumed by others. One product of bisexual erasure is the labeling of sexual orientation according to the gender of one's current partner (Vencill & Wiljamaa, 2016). Therefore, both partners in a same-gender relationship are assumed to be gay or lesbian, and both partners in a different-gender relationship are assumed to be straight. Further, when both partners identify as a sexual minority, they may vary in their

degree of "outness" in their social worlds such as work, family, children, and community members (Otis et al., 2006). Differences in outness, sexual identity, and degree of acceptance in each partner's family of origin may lead to conflict in the relationship and with family.

Mixed orientation relationships require a couple therapist to affirm two different sexual identities, interrogate their own biphobic assumptions, and consider the sexual scripts occurring between a given couple. Bisexuality may elicit fear, jealousy, and mistrust within the couple (Klesse, 2011) and lead to renegotiation of roles, boundaries, identities, or even dissolution of the relationship. Clinicians must be keenly aware of the impact of biphobia and bisexual erasure on these relationships in order to guide couples through these difficult conversations.

> Emily (a white, bisexual cis-woman) and Kiara (a Black, lesbian cis-woman) came to therapy two years into their relationship because of Kiara's concerns about their friend and occasional sex partner, Scott (a white, straight cis-man). Six months ago, the couple talked about opening up their relationship to include threesomes. Emily suggested her friend, Scott, because she occasionally missed having sex with men and felt comfortable with Scott. Kiara said she was willing to try it but wanted them to find a female third at some point.
>
> In session, Kiara cried as she recalled the last time they had sex with Scott, "It felt like I wasn't even there at times. Like the two of you were off in your own world and I don't even think you'd notice if I left the room." Emily was defensive and reminded Kiara that she could speak up and ask for what she wanted. "That's not true, Emily, and you know it." The therapist asked Kiara to say more. "Emily knows that I would never want to be in a relationship with a guy. But she could. She could be with a man and be happy. She could be with Scott and her life would be so much easier. She wouldn't be in a gay relationship and she wouldn't be in an interracial relationship. By doing this thing with Scott, I feel like I'm making it easier for her to jump ship." The therapist responded, "It sounds like you think your relationship is hard for Emily and, given the chance, she will choose an easier, more socially acceptable relationship. Is that right?" Kiara nodded. Emily sat quietly for a bit before she said, "I never thought of it like that. I didn't realize how threatening it might be for you to see me with a man…with a white man. I think maybe there's a lot we don't understand about each other's experience."

In this example, Kiara's fear that Emily would leave her for Scott is a byproduct of living in a heteronormative, patriarchal, and white supremacist society. She recognizes that a relationship between a white man and a white woman is held up as an ideal and has internalized stigma attached to her racial and sexual identities, which leaves her feeling insecure in her relationship with Emily. She also may feel that, as a woman of color, she has less power to ask her white partner for what she wants in the relationship. Emily had not considered the racial dynamics of their couple relationship or their relationship with Scott. This color blindness is a product of white supremacy, in which white people are taught that race does not matter and each person has equal power in society—even though that society is structured in a way that disadvantages people of color. Emily was right in that they both lacked awareness of their partner's intersectional identities, and the therapist can facilitate these conversations and help the couple create an equitable relationship.

Emily and Kiara's therapist may also want to address their agreement to be non-monogamous, to make sure that it is working for both of them. CNM is quite common among all sexual identities. Over 20% of adults have engaged in some form of CNM at some point in their life (Haupert et al., 2017). Although there are no specific prevalence rates for bisexual individuals, the type of CNM they report is diverse in form and function, ranging from polyamory to open relationships (Klesse, 2007). The configuration of any given CNM relationship structure will vary greatly in emotional and sexual boundaries, gender and number of partners, parenting responsibilities, and who lives in the home (Klesse, 2007; Pallotta-Chiarolli, 1995). Therefore, clinicians should

explore all aspects of a client's relationship structure and encourage them to identify agreements and boundaries that work for them and their partner.

For bisexual individuals, CNM may be a significant issue in their partnerships (Bowling et al., 2018; Li et al., 2013). They may need to negotiate the boundaries of their relationships and move past their own internalized biphobia in order to experience satisfaction (Bowling et al., 2018). Bisexual individuals may have internalized cultural messages that they are greedy or promiscuous and have difficulty asking for or participating in non-monogamy for fear of fulfilling a stereotype (Klesse, 2016). In the case of Emily and Kiara, Emily's defensiveness when Kiara cried about their last encounter with Scott may be influenced by her own internalized stigma. She may fear that Kiara will blame this situation on Emily's bisexuality, when really they both need to revisit their original agreement and have an honest conversation about what they want and they do not want from their open relationship. Clinicians need to be mindful of these messages and explore the fears, desires, and meaning of each partner regarding CNM not only as partners begin to open up, but throughout the relationship, as CNM is an ongoing process.

Yaribel and Kevin: From Parents to Co-Parents

Despite the fact that more than half (64%) of all LGB parents identify as bisexual (Goldberg et al., 2014), most research on LGB parenting does not distinguish between bisexual or gay and lesbian parents or only looks at them in the context of same-gender partnerships. In one study, cisgender bisexual men and women reported that friendship, open communication, handling conflict well (e.g. letting disagreements go, carefulness about bringing up a topic so as not to hurt their partner), and agreement on child responsibilities were important for a satisfying relationship (Bowling et al., 2018). They reported other typical parenting concerns, such as increased stress and reduced time and energy for their intimate relationship. And a few participants who were in consensually non-monogamous relationships reported that they closed their couple relationship to focus on parenting.

The transition to parenthood may bring about unique shifts for bisexual-identified parents, especially those in different-gender relationships. Bisexual women with male partners report decreasing connection to their bisexual identity, decreased disclosures, and increased discomfort from others in response to their identity (Goldberg et al., 2017, 2019). Parenthood may increase the perceived pressure to conform to heteronormative standards and to distance oneself from an identity that is seen as promiscuous, indecisive, or hypersexualized. Clinicians often participate in bisexual erasure by assuming that the sexual orientations of different-gender parents, in particular, are heterosexual or even irrelevant.

The relationships of some bisexual-identified parents will end in dissolution or divorce—the bisexual identity may or may not be a factor in the break-up. Some bisexual parents may choose to remain single after separating from their co-parent for a number of reasons: previous violence in intimate partnerships, other priorities in their life (e.g. raising children, career), or not feeling the need to actively pursue a relationship at this time (Bowling et al., 2018). If they do choose to re-partner, their bisexual identity and the gender of their new partner may be used against the bisexual parent in legal proceedings for child custody or to try to align the children against the bisexual parent (Holtzman, 2013). This can cause significant harm to the relationship between a parent and child and expose bisexual individuals to increased legal costs and biphobia in the legal system.

> Kevin (cisgender, heterosexual, Trinidadian man) called to make an appointment for his soon-to-be ex-wife, Yaribel (cisgender, bisexual, Dominican woman), saying she needed help with her "LGBT relationship." They had been married for 15 years, separated 6 months ago, and were in the process of finalizing their divorce when one of their sons told Kevin he saw his mother kissing another woman. Kevin informed his lawyer, stating that he did

not want his sons raised "by a bunch of lesbos" and sent Yaribel text messages accusing her of cheating on him, "switching sides," and setting a poor example for their children.

In session, Kevin told Yaribel, "You are just confused. You have been watching too much TV or talking with your friends too much. We didn't have those people back in the islands. You've become too American and I don't want my sons to be raised that way." Yaribel responded slowly, "I am so sorry you found out this way, Kevin. I promise I did not cheat on you and I did love you. I can't help who I love now. And it has not changed who I am as a mother." Kevin shot back, "How can you say you loved me and now you love a woman? You're not making any sense and this is why I am worried about my boys. They shouldn't be around you when you are so unstable."

In this example, after years of erasure, Yaribel's bisexuality is being highlighted now to paint a picture of her as unhealthy and unfit for motherhood. Kevin's confusion and anger are rooted in heteronormativity, the gender binary, and a misguided belief that bisexuality or LGBT relationships are an American phenomenon. Clinical intervention with this family would include sessions with Kevin and Yaribel to unpack Kevin's biases, facilitate productive communication, and help them come to a co-parenting agreement. For example, the therapist could highlight their shared parental commitment to their children becoming healthy and happy adults through goal-oriented and future-focused questions; the therapist could also discuss research that shows children do well after parents divorce when the parents can communicate well and do not make negative and disparaging comments about each other to the children. These negative comments and the heteronormativity and biphobia contained within would be discussed. Kevin would likely need individual sessions with the therapist to establish rapport and let him emotionally process the divorce and his current reaction to Yaribel's new partner. In conjoint sessions, the therapist can help outline topics that each should avoid with the children, including (and especially) romantic relationships each is engaged in. Later, sessions would include the children to establish Kevin and Yaribel as co-parents and to alleviate any confusion or distress about their mother's relationship.

Best Practices in Couple Therapy with Bisexual Partners

Clinicians cannot rely solely on evidence-based treatments or theory-based models when working with bisexual couples for two reasons. First, there are no outcome-based studies on couple treatment that explicitly identify bisexual partners (O'Shaughnessy & Speir, 2018); therefore, there are no evidence-based treatments for bisexual couple therapy. Second, most couple and family therapy models are insufficient for working with bisexual couples as they were created in a heteronormative context that assumes cisgender, heterosexual, child-bearing monogamous partners who are also white and middle-class. In more recent years, several models have been critiqued and expanded for working with queer couples (Addison & Coolhart, 2015; Allan & Johnson, 2017; Chapman & Caldwell, 2012) and those based on critical, postmodern theories such as social constructionism, constructivism, and queer theory may be inherently better suited for bisexual couples. These theories may offer possibilities for how to "do couple" or "do family" beyond heteronormative or binary terms (Hudak & Giammattei, 2014). However, there is no one model that is recommended for working with bisexual individuals and their partners. Rather, clinicians should use their preferred model for couple therapy, provided they consider the ways that power, privilege, and oppression are enacted by the language and theoretical concepts inherent in the model.

Reflexive Therapist Practice

Reflexive practice turns the topics and experience of therapy back on the clinician. For example, reflexive practice may look like a series of questions about the emotional, cognitive, and physical experiences of the therapist while in the room with a bisexual individual and their partner.

It may look like an open and compassionate inquiry into where these reactions come from and how they prevent the therapist from developing an affirming stance toward bisexual people. The idea is to generate curiosity for and commitment to increasing awareness and sensitivity for practice. Therapists are people who were also socialized in a biphobic society with often little chance to attend to implicit assumptions and negative stereotypes. Reflexive practice welcomes the use of the self as a tool for change.

When bisexual clients were asked what they wanted from a therapist, they asked for therapists to be interested in who they were and tempered in their reactions when they came out (Eady et al., 2011). Some reported intrusive and excessive questions about identity and sexual practices that made them wonder if the therapist was aroused, voyeuristic, and/or seeking confirmation of biphobic judgments. Whatever the intention, the outcome was discomfort for the bisexual client. The therapists in these situations were likely unaware of their impact on the client and only mildly aware of their own internal process. Reflexive practice would have clinicians ask themselves: *(1) When in therapy did you feel aroused or anxious? What did you do with this? (2) What parts of each client's story did you find most difficult to listen to? What did you do when you noticed this? (3) Which partner do you like better? What connection might this have, if any, with your shared or different identities? (4) As you consider your own reactions to the client's story, how do you think the couple was feeling in the room? What evidence do you have for their experience of therapy (e.g. body language, expressed feelings)?* These questions are meant to help the therapist look back on their experience and then consider the experience of the couple—they assume arousal and anxiety alert us to hidden judgments, biases, and assumptions which are expected human reactions to bisexuality when operating within biphobic societies; therapists do no good for themselves or their clients in denying they exist. The real benefit is in recognizing and deconstructing these belief systems.

For example, a couple therapist working with a bisexual individual and their heterosexual/lesbian/gay partner will need to affirm two different sexual identities while aligning with each partner and the relationship as a whole. One partner may fear their bisexual partner cannot be sexually faithful to them. If a therapist is reflexively considering this, they can resist the impulse to empathize with this fear *too enthusiastically*, or the kind of enthusiastic empathy that justifies the fear as legitimate (e.g. biphobia) and sets up an alliance with this partner, leaving the bisexual person to prove their innocence. As an alternative, a couple therapist would ask clarifying questions about the source and breadth of the fear: *Where did this fear emerge from? Is this unique to your partner or something you've feared in other relationships?* This could convey curiosity and implicitly challenge biphobia inherent in the fear. This same technique may also be useful as well for lesbian, gay, and transgender-including couples where other stereotypes, biases, and judgment can be barriers to effective care.

Centering Bisexuality

This chapter has provided an overview of the gender binary system, bisexual erasure, and minority stress and highlighted how each of these impacts the lives and relationships of bisexual people. If clinicians continue to build their awareness regarding these systems, they can center bisexuality and queerness in their practice, and decenter heteronormativity, mononormativity, and cisnormativity. Here are some examples of how centering might look:

- Noticing moments when the therapist assumes someone's sexual orientation, especially based on the gender of a client's partner or a client's gender expression. Practice not assuming.
- Treating bisexuality as a distinct sexual identity, unique from a gay or lesbian identity, and not a combination of gay and straight.

- Noticing any doubt or disbelief when someone discloses their bisexual identity.
- Don't ask them to "prove" it with questions like: *Have you been with someone of the same sex before? Are you more gay or straight?*
- Practice asking them what it means to them and what is important to them about their bisexuality.
- Practice asking *all* clients about their sexual identities and what is important to them about it.
- Make a conscious decision not to erase, forget, or ignore bisexual people.
- Talk about bisexual erasure. Point it out when it is happening in the room or in a story being told by the client.
- Assume all couples are mixed orientation couples and be surprised when they are not.
- Practice recognizing the impact of the gender binary system, cisnormativity, heteronormativity, and white supremacy on the lives of all couples.
- When a client or a partner expresses a bias based on the gender binary, gently explore it with them. Be patient with people as they are presented with new ways of viewing the world.
- Practice, practice, practice.

Conclusion

People who experience attraction to more than one gender are frequently erased or marginalized on a macro level in society and on a micro level in their own relationships. The gender binary system creates a context of heteronormativity and bisexual erasure that can lead to difficulty in forming and maintaining intimate relationships. Most problems experienced in bisexual partnerships are not unique—sex, parenting, jealousy, violence. However, they exist in a context in which bisexuality is stigmatized, marginalized, and erased. In this chapter, we presented a framework for practice with bisexual people and their partners that is grounded in the best available research, our own clinical experience, and a deconstruction of sociocultural discourse. Through continued reflexive practice, clinicians can center bisexuality in their couple therapy and guide partners to a new understanding of one another.

References

Addison, S. M., & Coolhart, D. (2015). Expanding the therapy paradigm with queer couples: A relational intersectional lens. *Family Process, 54*(3), 435–453. https://doi.org/10.1111/famp.12171

Alexander, J., & Yescavage, K. (2003). Bisexuality and transgenderism. *Journal of Bisexuality, 3*(3–4), 1–23. https://doi.org/10.1300/J159v03n03_01

Allan, R., & Johnson, S. M. (2017). Conceptual and application issues: Emotionally focused therapy with gay male couples. *Journal of Couple & Relationship Therapy, 16*(4), 286–305. https://doi.org/10.1080/15332691.2016.1238800

American Psychological Association. (2005). *Policy statement on evidence-based practice in psychology.* https://www.apa.org/practice/guidelines/evidence-based-statement

Balsam, K. F., & Mohr, J. J. (2007). Adaptation to sexual orientation stigma: A comparison of bisexual and lesbian/gay adults. *Journal of Counseling Psychology, 54*(3), 306–319. https://doi.org/10.1037/0022-0167.54.3.306

Blair, K. L., Pukall, C. F., Smith, K. B., & Cappell, J. (2015). Differential associations of communication and love in heterosexual, lesbian, and bisexual women's perceptions and experiences of chronic vulvar and pelvic pain. *Journal of Sex & Marital Therapy*, *41*(5), 498–524. https://doi.org/10.1080/0092623X.2014.931315

Bostwick, B., Boyd, C. J., Hughes, T. L., & McCabe, S. E. (2010). Dimensions of sexual orientation and the prevalence of mood and anxiety disorders in the United States. *American Journal of Public Health, 100*(3), 468–475. https://doi.org/10.2105/AJPH.2008.152942

Bowling, J., Dodge, B., & Bartelt, E. (2018). Diversity and commonalities in relationship experiences among self-identified bisexual parents in the United States. *Sexual and Relationship Therapy, 33*(1–2), 169–189. https://doi.org/10.1080/14681994.2017.1419565

Bradford, M. (2006). Affirmative psychotherapy with bisexual women. *Journal of Bisexuality*, *6*(1–2), 13–25. https://doi.org/10.1300/J159v06n01_02

Brennan, D. J., Ross, L. E., Dobinson, C., Veldhuizen, S., & Steele, L. S. (2010). Men's sexual orientation and health in Canada. *Canadian Journal of Public Health, 101*(3), 255–258. https://doi.org/10.1007/BF03404385

Breyer, B. N., Smith, J. F., Eisenberg, M. L., Ando, K. A., Rowen, T. S., & Shindel, A. W. (2010). The impact of sexual orientation on sexuality and sexual practices in North American medical students. *The Journal of Sexual Medicine, 7*(7), 2391–2400. https://doi.org/10.1111/j.1743-6109.2010.01794.x

Brown, T. (2002). A proposed model of bisexual identity development that elaborates on experiential differences of women and men. *Journal of Bisexuality, 2*(4), 67–91. https://doi.org/10.1300/J159v02n04_05

Brown, T., & Herman, J. (2015). *Intimate partner violence and sexual abuse among LGBT people.* The Williams Institute.

Chapman, D. M., & Caldwell, B. E. (2012). Attachment injury resolution in couples when one partner is trans-identified. *Journal of Systemic Therapies, 31*(2), 36–53. https://doi.org/10.1521/jsyt.2012.31.2.36

Cho, S., Crenshaw, K. W., & McCall, L. (2013). Toward a field of intersectionality studies: Theory, applications, and praxis. *Signs: Journal of Women in Culture and Society, 38*(4), 785–810. https://doi.org/10.1086/669608

D'Augelli, A. R. (1994). Identity development and sexual orientation: Toward a model of lesbian, gay, and bisexual development. In E. J. Trickett, R. J. Watts, & D. Birman (Eds.), *Human diversity: Perspectives on people in context* (pp. 312–333). Jossey-Bass.

Eady, A., Dobinson, C., & Ross, L. E. (2011). Bisexual people's experiences with mental health services: A qualitative investigation. *Community Mental Health Journal, 47*(4), 378–389. https://doi.org/10.1007/s10597-010-9329-x

Eisner, S. (2013). *Bi notes for a bisexual revolution.* Seal Press.

Fairyington, S. (2008). Kinsey, bisexuality, and the case against dualism. *Journal of Bisexuality, 8*(3–4), 265–270. https://doi.org/10.1080/15299710802501876

Feinstein, B. A., & Dyar, C. (2017). Bisexuality, minority stress, and health. *Current Sexual Health Report, 9*(1), 42–49. https://doi.org/10.1007/s11930-017-0096-3

Feinstein, B. A., Dyar, C., & London, B. (2017). Are outness and community involvement risk or protective factors for alcohol and drug abuse among sexual minority women? *Archives of Sexual Behavior, 46*(5), 1411–1423. https://doi.org/10.1007/s10508-016-0790-7

Feinstein, B. A., Latack, J. A., Bhatia, V., Davila, J., & Eaton, N. R. (2016). Romantic relationship involvement as a minority stress buffer in gay/lesbian versus bisexual individuals. *Journal of Gay & Lesbian Mental Health, 20*(3), 237–257. https://doi.org/10.1080/19359705.2016.1147401

Flanders, C. E., & Hatfield, E. (2013). Perceptions of gender and bisexuality: An exploration of the relationship between perceived masculinity, femininity, and sexual ambiguity. *Journal of Bisexuality, 13*(3), 374–389. https://doi.org/10.1080/15299716.2013.813418

Flint, C. (2004). *Spaces of hate: Geographies of discrimination and intolerance in the U.S.A.* Routledge.

Gates, G. J. (2011). *How many people are lesbian, gay, bisexual, and transgender?* https://escholarship.org/uc/item/09h684x2

Gates, G. J. (2014). *LGB families and relationships: Analysis of the 2014 National Health Interview Survey.* https://escholarship.org/uc/item/3g07q209

Gauvin, S., & Pukall, C. F. (2018). Sexual problems and sexual scripts: Overview and future directions for bisexual-identified individuals. *Sexual and Relationship Therapy, 33*(1–2), 34–44. https://doi.org/10.1080/14681994.2018.1426851

Goldberg, A. E., Allen, K. R., Ellawala, T., & Ross, L. E. (2017). Male-partnered bisexual women's perceptions of disclosing sexual orientation to family across the transition to parenthood: Intensifying heteronormativity or queering family? *Journal of Marital and Family Therapy, 44*(1), 150–164. https://doi.org/10.1111/jmft.12242

Goldberg, A. E., Gartrell, N. K., & Gates, G. J. (2014). *Research report on LGB-parent families.* https://escholarship.org/uc/item/7gr4970w

Goldberg, A. E., Manley, M. H., Ellawala, T., & Ross, L. E. (2019). Sexuality and sexual identity across the first year of parenthood among male-partnered plurisexual women. *Psychology of Sexual Orientation and Gender Diversity, 6*(1), 75–87. https://doi.org/10.1037/sgd0000307

Griffin, M. J. (2016). Intersecting intersectionalities and the failure of the law to protect transgender women of color in the United States. *Tulane Journal of Law & Sexuality, 25,* 123–144.

Haupert, M. L., Gesselman, A. N., Moors, A. C., Fisher, H. E., & Garcia, J. R. (2017). Prevalence of experiences with consensual nonmonogamous relationships: Findings from two national samples of single Americans. *Journal of Sex & Marital Therapy, 43*(5), 424–440. https://doi.org/10.1080/0092623X.2016.1178675

Holtzman, M. (2013). GLBT parents' rights during custody decision making: The influence of doctrine, statute, and societal factors in the United States. *Journal of GLBT Family Studies, 9*(4), 364–392. https://doi.org/10.1080/1550428X.2013.803346

Hudak, J., & Giammattei, S. V. (2014). Doing family: Decentering heteronormativity in "marriage" and "family" therapy. In T. Nelson & H. Winawer (Eds.), *Critical topics in family therapy* (pp. 105–115). Springer.

Klesse, C. (2007). *The specter of promiscuity: Gay male and bisexual non-monogamies and polyamories*. Ashgate.

Klesse, C. (2011). Shady characters, untrustworthy partners, and promiscuous sluts: Creating bisexual intimacies in the face of heteronormativity and biphobia. *Journal of Bisexuality, 11*(2–3), 227–244. https://doi.org/10.1080/15299716.2011.571987

Klesse, C. (2016). 'I did it my way…': Relationship issues for bisexual people. In L. Moon (Ed.), *Counselling ideologies: Queer challenges to heteronormativity* (pp. 135–154). Routledge.

Koh, A. S., & Ross, L. K. (2006). Mental health issues: A comparison of lesbian, bisexual and heterosexual women. *Journal of Homosexuality, 51*(1), 33–57. https://doi.org/10.1300/J082v51n01_03

Li, T., Dobinson, C., Scheim, A. I., & Ross, L. E. (2013). Unique issues bisexual people face in intimate relationships: A descriptive exploration of lived experience. *Journal of Gay & Lesbian Mental Health, 17*(1), 21–39. https://doi.org/10.1080/19359705.2012.723607

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129*(5), 674–697. https://doi.org/10.1037/0033-2909.129.5.674

Morgensen, S. L. (2011). *Spaces between us: Queer settler colonialism and indigenous decolonization.* University of Minnesota Press.

Ochs, R. (1996). Biphobia: It goes more than two ways. In B. A. Firestein (Ed.), *Bisexuality: The psychology and politics of an invisible minority* (pp. 217–239). Sage.

O'Shaughnessy, T., & Speir, Z. (2018). The state of LGBQ affirmative therapy clinical research: A mixed-methods systematic synthesis. *Psychology of Sexual Orientation and Gender Diversity, 5*(1), 82–98. https://doi.org/10.1037/sgd0000259

Otis, M. D., Rostosky, S. S., Riggle, E. D. B., & Hamrin, R. (2006). Stress and relationship quality in same-sex couples. *Journal of Social and Personal Relationships, 23*(1), 81–99. https://doi.org/10.1177/0265407506060179

Pallotta-Chiarolli, M. (1995). Choosing not to choose: Beyond monogamy, beyond duality. In K. Lano & C. Parry (Eds.), *Breaking the barriers to desire: New approaches in multiple relationships* (pp. 41–67). Five Leaves Publication.

Pieper, M., & Bauer, R. (2005). *Polyamory and mono-normativity: Results of an empirical study of non-monogamous patterns of intimacy* [Unpublished manuscript]. Research Center for Feminist, Gender, and Queer Studies, University of Hamburg.

RichardsFink, P. (2014, December 14). *Bisexual identity development: Perspectives, similarities, and contrasts* [Blog post]. http://fliponymous.wordpress.com

Rust, P. C. R. (Ed.). (1999). *Bisexuality in the United States: A social science reader.* Columbia University Press.

Steele, L. S., Ross, L. E., Dobinson, C., Veldhuizen, S., & Tinmouth, J. M. (2009). Women's sexual orientation and health: Results from a Canadian population-based survey. *Women & Health, 49*(5), 353–367. https://doi.org/10.1080/03630240903238685

Turrell, S. C., Brown, M., & Herrmann, M. (2018). Disproportionately high: An exploration of intimate partner violence prevalence rates for bisexual people. *Sexual and Relationship Therapy, 33*(1–2), 113–131. https://doi.org/10.1080/14681994.2017.1347614

Vencill, J. A., & Wiljamaa, S. J. (2016). From MOM to MORE: Emerging research on mixed orientation relationships. *Current Sexual Health Reports, 8*(3), 206–212. https://doi.org/10.1007/s11930-016-0081-2

Walters, M. L., Chen, J., & Breiding, M. J. (2013). *The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 findings on victimization by sexual orientation.* National Center for Injury Prevention, Centers for Disease Control and Prevention.

Warner, M. (1991). Introduction: Fear of a queer planet. *Social Text, 29*, 3–17.

Weinberg, M. S., Williams, C. J., & Pryor, D. W. (1994). *Dual attraction: Understanding bisexuality*. Oxford University Press.

Whitton, S. W., Newcomb, M. E., Messinger, A. M., Byck, G., & Mustanski, B. (2019). A longitudinal study of IPV victimization among sexual minority youth. *Journal of Interpersonal Violence, 34*(5), 912–945. https://doi.org/10.1177/0886260516646093

Worthen, M. G. (2016). Hetero-cis–normativity and the gendering of transphobia. *International Journal of Transgenderism, 17*(1), 31–57. https://doi.org/10.1080/15532739.2016.1149538

Yoshino, K. (2000). The epistemic contract of bisexual erasure. *Stanford Law Review, 52*(2), 353–461.

7
Therapists' Accountability and Engagement with Transgender and Nonbinary Couples

LIVINGSTONE CARTER COX, KRISTEN E. BENSON and ALEX IANTAFFI

The clinical scene is familiar, even though the details might change: a therapy room, a couple looking expectantly at you, their brand-new therapist, for support. They have been feeling stuck for some time, worried about the future, the sustainability of their relationship, and someone suggested getting therapy. Now they are sitting across from you, ready to begin.

Take a moment to really imagine the scene in your mind's eye. What does the room look like? Maybe it's your actual office, or an imaginary ideal office. Who are the people sitting across from you? What is their age, gender, race, ethnicity, citizenship status? Are they disabled, affluent, working-class, educated, and religious? Who do you imagine the couple to be? Take a moment to imagine who is sitting across from you. Chances are that your imagination will have created a familiar scenario, whatever that might be for you. You may or may not be surprised by the scenario brought forth by your imagination. It is also likely that if you are cisgender (your sex assigned at birth aligns with your gender), you have imagined the couple to also be cisgender. This may, of course, not be the case if you work frequently with trans and/or nonbinary people, if you are trans and/or nonbinary, or if you expected someone in the couple to be trans and/or nonbinary because of the title of this chapter. We use the term trans as a term to indicate anyone who identifies as such and/or whose sex assigned at birth differs from their gender identity. We use nonbinary in a similar way to indicate anyone who identifies as such and/or whose gender identity is outside or across the gender binary. Let's get back to our couple. Who are they? What are they looking for? Why are they in your office? Basically, what are the assumptions you are making right now about them, and why do they matter?

We know from often-quoted research evidence that the therapeutic relationship is the most important predictor of success in therapy, regardless of the theoretical approach used by the therapist (Blow & Sprenkle, 2004). We are confident in asserting that most, if not all, therapists and counselors strive to have a strong therapeutic alliance with their clients, as this is the container for the work that happens in and between sessions; however, several factors can get in the way of that therapeutic relationship. Factors such as therapist's identity, lived experience, and comfort with and knowledge of the clients' identities and lived experiences can be incredibly influential throughout the therapeutic process. When a trans and/or nonbinary client enters the room, they do not do so in a vacuum. This means that they might be worried, for example, about whether they will be pathologized, given the long history of transphobia in our field (Ansara & Hegarty, 2012; Blumer et al., 2013). Whether we as therapists are trans, nonbinary, or cisgender as clinicians, we have a responsibility to know that historically and currently, trans and/or nonbinary people are pathologized, subject to stigma, face stereotype threat, and are subjected to gatekeeping and other inequitable practices in health care, including the field of mental health. This awareness is essential if we do not want our therapy room to become a mirrored

DOI: 10.4324/9780429274626-10

room (Hare-Mustin, 1994) reflecting the same transphobia and cisgenderism (the ideology that cisgender identities and experiences are inherently superior to those of trans, nonbinary, and gender-expansive people) that are found outside the therapy room.

Our own identity might play a part in establishing a sense of trust. For example, two of the authors are visibly trans and/or nonbinary, and this can help trans clients feel safer faster; however, they may also have challenges in establishing trust with cisgender partners or cisgender parents of trans people because of these identities. Further, even though we might share identities with our clients, it does not mean that we also have the same experiences, given that we might come from different racial, ethnic, religious, geographical, or economic backgrounds. We might also have different views about what it means to be trans and/or nonbinary. This means that regardless of our identities, experiences, or theoretical frameworks, we need to first consider trust. What helps us build trust with the couple sitting across from us? We suggest that reflective practices that challenge us to look at our own assumptions, stories, bias, and beliefs in relationship to gender are essential. These practices need to also be accompanied by knowledge and competence in working with trans people and their relationships. This knowledge and competence are, of course, ever-evolving and need to be kept up to date.

We begin this chapter by exploring therapists' own identities and positionality. We intend to start by inviting the reader to consider self-reflection and accountability practices before moving into a discussion about couple therapy with transgender and nonbinary couples and relationships.

Positioning as Accountability

We invited you earlier to imagine what the couple sitting across from you looks like and asked you to reflect on your assumptions. We then went into more depth in framing what has come before us, before the moment that the couple walked into the therapy room, and how what has come before us historically, culturally, and socially informs this imaginary moment, with this imaginary couple sitting across you. One of the things that has come before us historically on the land currently called the United States, where we, the authors, live, is a history of settler colonialism. We want to consider this history, given that historical evidence documents how gender expansiveness beyond and outside of the binary existed/exists in many tribal nations and languages. Colonizers were confounded enough by this that they wrote about it, created the now-considered offensive term *beardache* to talk about people who did not fit into a rigid gender binary, and proceeded to suppress and destroy its existence, as much as possible. This history means that in many ways, the ideology of cisgenderism, which views cisgender people as the "biological norm," is inextricably linked with settler colonialism first and then with the creation of whiteness in order to establish white supremacy (Binaohan, 2014).

When we consider gender, therefore, we cannot do so outside of culture, society, and historical systems of oppression. This can seem challenging or even impossible; however, throughout this chapter, we do our best to keep in mind that gender cannot be considered apart from other aspects of our identities, histories, and social status. For example, take a moment now to consider how your gender is shaped by your class, economic status, race, ethnicity, religion, disability, citizenship, indigeneity, and so on. You do not need to consider each of these aspects all at once if that is too overwhelming. If this is a new practice for you, you might want to look at one to two aspects at the time, initially, alongside gender. For example, Alex reflects here on these points:

> When I think about my gender, I think about a certain degree of freedom I experienced in my childhood growing up in Rome, Italy, a large, metropolitan city. However, that freedom was usually restricted when I visited my great-aunts in Sicily, something that I did

several times a year growing up. There my sex assigned at birth meant that I could not walk with boys by myself, that I was expected to sit with my legs closed, and to generally perform a more compliant femininity than what was expected of me back in Rome. Both experiences shaped my sense of gendered self. Age and time did too. As an adolescent, I started to realize that I could only see boys as romantic interests and not friends. There was an unspoken division setting in and I was supposed to pick the 'right' side, that of femininity. When in my 20s I started to realize my queerness in sexuality and then in gender, it felt impossible, for me, to live where I grew up and I ended up moving to the UK. To this day, over two decades later, it still feels impossible to be my authentic self and be safe when I visit Italy. This has also led to a sense of displacement from my relationship to land and ancestors. Growing up I had a sense of belonging and as a Sicilian of Indigeneity to place. I belonged in the Mediterranean in ways that I can never belong elsewhere. My displacement and immigrant experiences are inexorably connected to my gender identity. However, as an immigrant, I am also restricted in my choices around affirming my gender. For example, I have not applied for a nonbinary license, even though I could where I live, because this could be detrimental to my citizenship application process. My transgender status also means that I am afraid of what will happen when someone reviews my file once I apply for citizenship given that the administration has changed from when I applied for my green card. Finally, presenting as trans masculine, I often feel pressured to perform masculinity in a way that prizes physical strength. As a disabled person whose disabilities are invisible, this can lead to challenging moments in which the gendered expectations placed on me and my physical capacity do not match. For example, I look strong enough to outsiders, yet I might need to ask someone for help to open a bottle of water while traveling. My gender is shaped by all these experiences and aspects of my identities and they are also shaped by my gender, in a circular relationship.

Then revisit who you imagined the imaginary couple at the beginning of this chapter to be. Are they like you or not? What informs you when you sit across new clients and take in their initial stories? This also seems like the right moment to tell you, the readers, a little more about us, the authors. After all, if we are asking you to position yourself in relationship to gender and your identities and experiences, it seems only fair that we strive to do the same so that you can consider what we write through those lenses.

Alex is a trans masculine, nonbinary, disabled person. They are originally from Italy, where they were brought up, and have lived on Dakota and Anishinaabe land, currently known as Minneapolis, Minnesota, since 2008. Before that, they had lived in the UK for 15 years, where they were initially trained as a systemic psychotherapist. This means that Alex has the experience of being an immigrant with white privilege while also not being brought up in an Anglo-dominant context. In addition to being a licensed marriage and family therapist, they are also a clinical supervisor, somatic experiencing practitioner, sex therapist, independent scholar, and author. Alex is also a parent, community organizer, and is passionate about healing justice and contributing to the creation of learning spaces outside of academia.

Livingstone (Stone) is an Afro-Guyanese-American, maverique (independent of the entire concept of the gender binary) person living with multiple invisible disabilities. Raised in both Brooklyn, New York, and Durham, North Carolina, they were trained as a Couple and Family Therapist at Syracuse University and is a doctoral candidate in Human Development and Family Science at Virginia Tech. A first of its kind, their doctoral dissertation focuses on the being, becoming, and belonging processes of Black transgender men. Stone now utilizes their passion for intersectional, trauma-informed compassionate care as the Assistant Director for the Office of BGLTQ Student Life at Harvard University, situated upon the traditional land of the

Massa-adchu-es-et (Massachusetts) tribal nations. Their independent scholarship focuses on how Black transgender, nonbinary, and intersex people embody a critical intersectional futurism, and a radical spiritual consciousness that holds keys to intrapersonal and interpersonal liberation.

Kristen is a queer, Scandinavian-descent, white, cisgender woman who is a single parent in an open adoption with a nonbinary birth parent. She was raised in New Jersey and Florida, and currently resides on what was originally Cherokee land in North Carolina. She is a faculty member where she trains and supervises master's family therapy students. Her scholarly work centers on social justice and inclusion in therapy and focuses on transgender and nonbinary inclusion. She is in ongoing reflection about her positionality and ways to advocate for transgender and nonbinary people through accountability practices with other cisgender therapists. She shares her academic platform in an effort to create opportunities for transgender and nonbinary people to share their stories.

By acknowledging our positionality, we are aiming to be transparent and accountable in our roles as authors. We allow you, the reader, to have a sense of how our lived experiences may influence what and how we address topics in this chapter. In the next section, we discuss how establishing communities of accountability is key to this trust-building process.

Therapists' Communities of Accountability

The majority of practicing clinicians are cisgender, and given the hardships faced in a culture that privileges cisgenderism and heterosexuality, many transgender and nonbinary clients will seek services with cisgender clinicians. Thus, we find it important to speak directly to cisgender therapists about the importance of accountability practices.

Accountability practices require that cisgender clinicians actively seek opportunities to continue learning and engage in ongoing conversations to reflect on their cisgender privilege, which refers to the unearned advantages a person has when they experience congruence with the sex they were assigned at birth and their gender identity. Examples of cisgender privilege include being referred to by accurate pronouns and not experiencing couple therapist's assumptions that the gender identity of your partner is a crisis. Accountability practices require that cisgender therapists take initiative to read updated literature on gender identity and attend ongoing trainings. It is also imperative that they consider impact over intention; too often, we have witnessed cisgender therapists self-proclaim allyship but continue approaching clinical work in a manner that does not increase safety or inclusion for transgender and nonbinary clients. For example, we can think of examples when a cisgender therapist is well-intentioned and wants to be welcoming to transgender and nonbinary clients but lacks basic understandings about gender identity and relies on clients to educate them. A well-intended clinician might also assume that couples who include at least one binary partner are seeking therapy because of gender identity, rather than approaching couples therapy as open and curious about a range of couple experiences. Cisgender therapists must ask not only what intentions they are setting for gender inclusivity, but what is the impact and outcomes of those intentions.

Similarly, it is important for transgender and nonbinary therapists, as well as therapists who are partnered with transgender people, to seek out accountability partners and groups in order to be aware of how one's own experiences related to gender may be challenged by a client's different yet related journey. Transgender or nonbinary therapists, or therapists partnered with them, might come across issues that resonate for them. It is important to consult with peers and supervisors; yet, these people can also be affected. When one sees one's own relationship dynamics mirrored back to them, it can be hard to be direct. When the supervisor team knows of one's relational dynamics, it can be difficult to be direct in a similar way. The therapist had some difficulty with similar issues in their own life. Take, for example, a supervisor working

with a cisgender therapist-in-training who was partnered with a transgender person. The supervisee, who was working with a couple that included a cisgender woman and trans masculine partner, struggled to ask important questions of the couple because she feared bringing up gendered tensions that existed in her own relationship. Transgender and/or nonbinary therapists might also come across issues that resonate in their own lives, and when this is the case, it is important to consult with peers to ensure that we become aware of any implicit bias we might be experiencing.

We encourage all therapists to participate in accountability communities, which may include two or more clinicians who talk regularly about justice and inclusion. When a question arises or they have a concern that they may have committed a microaggression, they can rely on the group to question, process, and improve their gender-inclusive work. Accountability communities may engage in books clubs that contribute to a necessary knowledge base, such as *Life Isn't Binary* (Barker & Iantaffi, 2019) or *The Transgender Teen* (Brill & Kenney, 2016). Therapists who participate in accountability communities are in ongoing reflection about their own cisgender privilege and positioned to be lifelong learners about gender identity and gender-inclusive practice. They do not burden transgender and nonbinary clients or colleagues with the responsibility of educating them about their privilege or risk re-traumatizing clients by positioning them to speak about transphobia when it is not otherwise indicated. Cisgender therapists who want to push against cultural gender norms and act as an agent of change recognize the value in taking responsibility for learning and seeking educational opportunities in a manner that does not require the emotional labor of transgender and nonbinary people. Rather, they stay current on social issues such as legal initiatives to support transgender and nonbinary people as well as community concerns, such as incidences of violence and murder reported in the media which can impact the experiences of transgender and nonbinary clients they work with.

This positioning shift is not new to marriage and family therapists, as the field was formed as an act of resistance to traditional psychology. It is imperative to dismantle gender-normative supremacy, which polices and limits human experience in order to avoid becoming unwitting agents of supremacy. When we are not actively taking action against supremacy, we risk becoming complacent in systems that support it, as seen in actions to limit transgender and nonbinary people's ability to safely access medical care, supportive mental health care, employment, housing, public restrooms, and engage in daily activities free from discrimination.

Intersectionality as an Ethical Imperative

> Twenty-six-year-old Beaux, a Black transgender man, and his partner, a 30-year-old white cisgender woman, seek clinical support for on-going relational distress. Beaux awakened to his affirmed gender three years prior and pursued gender affirmation procedures without the support of his partner, Nicole. You are the third therapist they are seeking guidance from, as Beaux has received little help with how his overall distress and discomfort is linked to his transition to an often criminalized and hypersexualized Black manhood, and Nicole has felt unheard and unsupported. Nicole identifies as a lesbian and does not agree with the use of hormone replacement therapy. Both Beaux and Nicole state they love each other and would like to work with someone who can understand and navigate their individual concerns and their relational difficulties.

The therapy room has the possibility of serving as a liminal space, an *other-world* that transitions clients from the present into a desired reality; however, for many transgender people, the therapeutic space can often mirror the white ableist, cis-centric ideals that are ever-present in global society. For example, in 2014, activist and actress Laverne Cox graced the cover of *Time Magazine*, marking a tipping point for transgender visibility (Steinmetz, 2014).

This national acknowledgment of the existence of not only transgender people, but also of a Black transgender woman marked a time when transgender and nonbinary people existed in a political era where visibility and gender-affirming legislative policies were beginning to converge toward granting social and legal humanity to those who do not identify as cisgender (Associated Press, 2014). However, since 2016, these policies have been systematically reversed by the current presidential administration (National Center for Transgender Equality, 2019), thus leaving already underfunded, underserved, and under-researched transgender communities in a human rights crisis that mental health professionals need to be equipped to support. For those who are multiply marginalized (i.e. transgender people of color), therapy has the ability to range from microaggressive to traumatic, given limited shared representation in available therapists and lack of anti-racist, trans, and nonbinary competent training of white cisgender therapists.

Given psychology's history of colonization practices (Duran, 2006), we argue that it is an ethical imperative for therapists to not only invest in their own liberation but to also divest from the fallacies of domination. Incorporating an intersectional paradigm (Crenshaw, 1989) allows us to navigate through, within, and around a matrix of oppression that prioritizes minds and bodies that are (or are in close proximity to) white, male, Christian, able-bodied, thin, cisgender, heterosexual, neurotypicality. This is the basis of an illusion through which we are all conditioned to see ourselves and others. What is beyond the veil of cisgenderism? How do we go beyond the veil of white supremacy? A decolonized, anti-racist, queer view of ourselves, our clients, and our approaches can lead us toward a more just practice and more empowering work (Binaohan, 2014).

We encourage therapists to consider the following questions as a means to organize and create structural change to shift toward an inclusive consciousness over time:

1. What legal identity documents do you require to access your practice?
2. Does your practice have a non-discrimination policy that includes gender identity?
3. Is your physical space accessible and inclusive of gender-affirming rest areas?
4. Does your administrative paperwork reinforce binaries and boxes? Can your clients see themselves thought about and reflected in your paperwork and/or in-take materials?
5. Do you lead with your pronouns? Do you ask every client how they would like to be referred to?
6. Is your practice sex, body, and kink positive? Do you make room for the possibility of non-monogamy? Do you acknowledge the diversity of chosen family and queer parenting structures?
7. Is your practice rooted in conscious capitalist or anti-capitalist practices? Who has financial access to your services?

Transition as a Dynamic Process One entry point to begin this thought process is to interrogate and disrupt the notion of "transition." "Transitioning" refers to the process that some transgender or nonbinary people may undergo to align their gender expression to their gender identity. This may or may not include gender affirmation procedures like hormone therapy or body modification surgeries. Containing the transgender experience within the notions of a medicalized unilateral transition process not only pathologizes these identities, but it also reifies a cis-centric binary. This singular perspective creates a monolithic transgender experience that prioritizes a man/woman, male/female dichotomy. Gender transition is a unique journey specific to each person and each relationship. This dynamic process can shift and change over time and may or may not have a specific destination. As one awakens into their gender and sheds the hold of cisgenderism, gender becomes a sort of blooming as opposed to an accomplishment. In other words, we are all in a constant state

of becoming, including when it comes to our gender. As clinicians, it is important to keep this in mind, as clients may need support as they traverse these processes in the midst of interpersonal and systemic transphobia.

Clinicians may follow the World Professional Association for Transgender Health (WPATH) Standards of Care (SOC), which is considered the global ethical practice standards for medical and mental health treatment of transgender people (WPATH, 2019). While recent revisions are more flexible and relational than previous versions, the SOC continues to rely on the *DSM-5* diagnosis of gender dysphoria (American Psychiatric Association, 2013), which reflects psychology's historical conceptualization of gender as binary (Schulz, 2018). A primary critique of the SOC is the positioning of therapists as gatekeepers to determine a client's readiness for transition. In an effort to move away from a distress model, therapists may instead embrace the Informed Consent Model, which positions the therapist as a resource to discuss all aspects and consequences of transition procedures while maintaining client autonomy in the decision-making process (Schulz, 2018). Therapists should be critically aware of approaches to transition and how they support trans and nonbinary people and their partners in this process.

In the case of Beaux and Nicole, the therapist is tasked with supporting Beaux's sense of himself and related goals while holding space for Nicole to explore how her sexual orientation is linked to her beliefs about gender identity, and how those beliefs are reflected in culture, impacting her relationship. The distress this couple faces is not related to gender dysphoria, but rather to cisgenderism. For example, as Beaux's masculinity is affirmed in social situations, Nicole may feel that her lesbian visibility is erased by focusing on external (in)validation. The therapist may explore how the social gender norms that contribute to homophobia and heteronormative bias also create and fuel transphobia and cisgender bias within their relationship. For example, the therapist may interview the couple about the intrusive nature of social norms and contemplate if they are ok with this. They may inquire about the aspects of their relationship that gender norms undermine, and how might the couple stand up to these norms together.

For example, the therapist could use externalizing, a narrative therapy intervention, to ask questions such as:

- It sounds like social norms around gender and sexuality really impact you both, although in different ways. What relationship do you want to be in with these social norms?
- How much power do these social norms have on your relationship?
- If these social norms did not have as much power over your relationship, would things be different between you? If so, in what ways?
- Is there a way in which you could "team up" against these social norms? What would that look like?
- If you were to stand up to these social norms, either individually or together, what would become possible? What would standing up to these social norms look like?
- If these social norms were to disappear overnight, what would be different in your relationship, if anything, and who would notice any potential differences?

Notice we have not suggested that the therapist focus on the grief of the cisgender partner, as this dominating narrative is informed by gender discourse and focuses on the experience of the cisgender partner while exposing the trans/nonbinary partner to harmful or rejecting messages; therefore, we encourage exploration of the discourse itself.

Supporting Trans People of Color As we begin to understand and see the realities of transphobia, we must recognize the standpoint of those navigating trans-antagonism as racialized people.

Transgender people of color (TPOC) exist simultaneously within and through racism, transphobia, classism, and many other sites of oppression. From institutional to interpersonal discrimination, TPOC suffer from disproportionate rates of poverty, homelessness, incarceration, food insecurity, intimate partner violence, sexual trauma, and mental health issues (Lefevor et al., 2019). More than 18 Black transgender women have been murdered in 2019 at the time of this writing (Human Rights Campaign, 2019), and LGBTQ anti-discrimination laws are still being debated in our highest courts (Human Rights Campaign, 2019; Ring, 2019). Getting out of bed is a revolutionary act for TPOC living in chronic multiple minority stress (Balsam et al., 2011; Singh & McKleroy, 2011). This sociopolitical reality leaves little accessibility for a reality and environment that welcome the humanity and dignity of transgender people of color, which has prompted the development of podcasts and social media sites as resources (e.g. the Brown Boi Project, QTPoC Mental Health Facebook page), and conferences (e.g. Black Trans Advocacy Conference), while little is published in refereed journals and primary clinical resources for therapists. Therapists are among the helping professionals at the frontlines of this public health crisis, and therefore have a responsibility to practice in an anti-racist manner.

Consider the earlier vignette. As a therapist, how might you ask about Beaux's identity as a Black man? For example,

- Is he connected to a community of TPOC?
- How do he and Nicole navigate their biracial couplehood?
- Has he disclosed his gender identity to his family?
- How have they responded to his being partnered with a white woman?
- Has Nicole's family supported their relationship?

Orienting Yourself in Gender-Inclusive Work

You may feel overwhelmed if the ideas discussed are new to you, or you might be ready to focus on a more clinical discussion of these matters. Wherever you are, take a moment to notice what concepts might feel familiar and which do not. Just like when new clients come to therapy, we take the time to orient them to what to expect, we want you to take a moment to orient yourself to the frameworks, assumptions, and ideas informing this chapter and that we have attempted to briefly introduce to you. If you disagree with us, take a moment to notice in what way you disagree, why, and what informs your views. Knowing where you are in the gender landscape, where your clients are and where they might or might not want to be is an essential part of this work. Take a moment to get your bearings in this intersectional gender landscape before we proceed to consider issues arising in therapy when working with couples in which at least one person is trans and/or nonbinary.

Recommendations and techniques for gender affirmative therapy have been well documented (Singh et al., 2017); however, very little exists on the unique relational processes that occur between and among transgender people, nonbinary people, and cisgender people. As transgender and nonbinary communities are still fighting for fundamental rights, many of the relational conversations are still discussing a monolithic transgender experience. Understanding the within-group difference of gender-non-conforming people is significant for assisting with nuanced relational dynamics. What does it mean to be a transgender person in a relationship with a cisgender person? What does it mean to be a queer, nonbinary polyamorous relator? How do transgender people handle platonic intimacies and/or hook-up culture? How do we work with mixed orientation transgender couples?

Transgender-Inclusive Couple Therapy

You are meeting with a couple for an intake session. The referral intake indicates that Eduardo is a 56-year-old heterosexual transman who immigrated to the United States

from El Salvador 1 year ago seeking asylum and has remained undocumented. He has experienced trauma and fears returning to El Salvador due to threats based on his identity as a man. He is partnered with Janelle, a 39-year-old bisexual feminine nonbinary person who is a second-generation U.S. citizen of Mexican descent. The couple met in a homeless shelter nine months ago and recently moved into an apartment together. Janelle lives with chronic pain and struggles to maintain full-time employment due to both her medical condition and likely discrimination related to her nonbinary presentation. Eduardo has struggled to find employment due to his pending citizenship status.

Consider how you might initially greet this couple. Where do you start? What assumptions are you making about them? How did they come to find you as a gender-inclusive couple therapist? How do you respond when you learn that Eduardo's primary relationship concern is his jealousy when Janelle wears revealing clothes, and that Janelle is most concerned with Eduardo accessing testosterone "on the street" and his lack of regular access to clean injection needles? Did you anticipate these concerns as dominant relationship issues, or did you make other assumptions based on their positionality and your own?

This couple brings up multiple concerns, including gender transition, immigration, transition, disability, employment, housing, and poverty. Although each concern is relevant and complex for transgender and nonbinary people, all are issues that are interrelated and exist in relationship with each other. It is impossible for therapists to hold expertise in each of these areas, yet a competent therapist will understand the interconnectedness of disparities as well as the resilience and strength this couple exemplifies.

Mixed Orientation Relationships

In the case example, Eduardo identifies as a straight man while Janelle identifies as bisexual. As such, their differing sexual orientations establish what is referred to as a mixed orientation relationship. When we expand our understanding of gender and sexual orientation beyond prescriptive heteronormative and cisgender-normative ideals, we are open to possibilities given the complexity of human connection, love, and pleasure. To be subversive in this way is to honor the multitude of relational dynamics and experiences. We argue that therapists must be willing to challenge dominant norms regarding couples and relationships in order to provide inclusive services to all clients who seek our help.

We suggest that therapists embrace mixed orientation couples as a norm, as they challenge heterosexism and binary thinking. More specifically, this approach challenges the belief that humans are limited to two genders, that they are limited to being gay or straight, and that both partners must share the same sexual orientation. Unfortunately, the invisibility of mixed orientation couples serves as a barrier to inclusive couple therapy with transgender and nonbinary couples. For example, it is not unusual for a couple who was once perceived as straight and stays together through a partner's transition to be seen as a lesbian couple without questioning how each partner actually identifies. A therapist who lacks awareness that being read as a lesbian couple may affirm a trans feminine partner's gender identity while simultaneously mis-assuming the cisgender partner's sexual orientation identity may miss a key concern for the couple. Similarly, a pansexual transgender person may partner with a cisgender straight person and be misread socially as a straight, marking the relevance of an aware therapist critical.

Sex Therapists' ability and comfort in addressing sex with transgender and nonbinary relationships is critical to inclusive work. We must maintain awareness and sensitivity regarding the culturally gendered nature of naming body parts and how clients refer to their own and

their partner's bodies as well as sexual and pleasurable activities. In-depth discussion about sex therapy extends beyond the scope of this chapter, and we recommend Iantaffi and Benson (2018) for further reading.

Relationships between Transgender and Cisgender Partners

Let's go back to the couple we met at the beginning of this chapter and assume that one of them is cisgender, or cis, that is that their sex assigned at birth aligns with their gender identity. One of the scenarios you may have imagined is the couple being there because one person is in the process of transition or has just come out as trans and/or nonbinary. This is probably one of the most common scenarios in our collective imagination. This scenario is often accompanied by several assumptions rooted in the prevalent levels of cisgenderism in the dominant culture. For example, one of the assumptions is likely to be that the cis partner is distressed by their partner "coming out," that they might feel betrayed or even tricked. This plays into the stereotype of trans people as tricksters who try to lure cis people into a relationship without disclosing their trans and/or nonbinary identity, even though they have been aware of this all along. This is a common trope in mainstream media, including movies and documentaries, and as therapists, we need to be vigilant to not give into easy tropes that are a reflection of transphobia and cisgenderism. Another common assumption might be that, if there are children, they will be negatively impacted by the trans/nonbinary partner coming out. You may start to see a common thread in these assumptions, that is the centering of the experiences and feelings of the cis family members, as well as a centering of cisgender as the norm, and trans/nonbinary genders as deviating from such norm.

For example, one of us (Alex) has often worked with trans individuals, especially trans women, whose spouses refused to engage in family therapy. The trans client was usually carrying crushing levels of guilt about having "broken up" their family by coming out. However, when asked how it felt when their wife of 10/20/30+ years refused to come to family therapy for a session, the trans clients seemed disoriented. What did the therapist mean? They were the guilty party, not their cis partner who could choose to not stay married to them. This is a reframe that, while initially disorienting, is also systemic and re-centers the family system by highlighting that everyone in the system is making choices. While the trans/nonbinary person is choosing to disclose their gender identity, the other adults in the system are choosing their responses to this change. This challenges the trope of the "innocent" cis partner being duped by the "evil trickster" trans/nonbinary person by placing the responsibility for the cis partner's actions and choices back on their shoulders. Change itself can then be framed as something that happens in long-term relationships. Our bodies change through age, as does our sex drive, our interests, sometimes our religion or spirituality, and our health. Can gender be considered alongside these changes? Of course, this change, like other changes, may or may not be sustainable for the family system, but that is indeed something that can be explored in therapy. Let's take a moment to look at another clinical vignette.

> Bo has been married to Louise for 25 years. Their last child left home last year, and Bo came out as a trans feminine non-binary person six months ago. Initially Louise had refused to come to therapy, but eventually she agreed to attend one session at the therapist's direct invitation (with Bo's consent and a release of information signed and in place). Bo and Louise have been in therapy before to deal with being an interracial couple (Bo is Somali-American, and Louise is white, French-Canadian) and most recently to address concerns over their oldest child's struggles with depression and anxiety.
>
> After going over introductions and confidentiality and its limits, the therapist starts the conversation by thanking Louise for coming to the session today.

Louise: I don't see what I am doing here. Apparently, Bo is not the man I married, in fact, he's not even a man. I don't see that there is a marriage to talk about. I'm straight. Bo has come out. The children are gone and have their own lives. So, I guess this is the end for us, all there is to talk about is our divorce and lawyers are more useful than therapists for that.

Bo sits quietly and does not say anything.

Therapist: Louise, did Bo say they're no longer in love with you, or that they want a divorce?

Louise: No, not like that, but they don't need to, right? I mean how many trans people do you know that stay married to their wives?

Therapist: I know a few. Bo, do you want to get divorced? How do you feel about Louise and your marriage?

Bo: I am still very much in love with Louise. We've gone through so much together and she is the love of my life. I just needed to be myself. I thought these feelings would go away, but they never did. I didn't want to be dishonest with her, not anymore.

Therapist: You mean the feelings about your gender?

Bo: Yes.

Therapist: Louise, how is it landing to hear Bo say those things about you, about how they still love you and want to be with you, but also be their authentic selves, to use my own words, with you?

Louise: I feel angry. What am I supposed to do? I married a man. They are not a man.

Therapist: Are there other aspects of Bo you appreciate besides the fact that you thought they were a man? For example, any qualities they have that you love?

Louise seems disoriented: Well, Bo is the kindest person I've ever met, he works hard and is always happy to see me and the children, well was happy to see them, they're all gone to have their own lives now. I just never thought I would be alone in my 50s. I thought we would grow old together.

Bo: We still can…I want that.

Therapist: Louise, I understand that this is not a change you were expecting but I know you and Bo had gone through many other changes and challenges together successfully. Is this change so insurmountable?

Louise: I think so.

Therapist: It may be. It is for some people. Some people also find a way to make their marriage work. Would you be interested in exploring that? For example, we could agree to work together for the next six months and see how it goes. Would you both be willing to try that?

Louise: I guess so. After all, six months is not that long after you've been married for twenty-five years. But (turning to Bo) only if you're not lying about wanting to be with me.

Bo: I love you. I would love to try please. I didn't lie to you about my gender. I just couldn't make sense of it for a long time. But our love still makes sense, it always has made sense to me.

Therapist: Ok then, it seems we have an agreement. Of course, we can review this at any time.

At this point you may feel it is fine for Bo and Louise to address this in their marriage because their children are grown but what about when children are younger? What about the children indeed? When one of us (Alex) came out as trans masculine and nonbinary, their biological child was then four years old. She had already met other trans and nonbinary persons since Alex and their cis partner and biological parent of their child were already part of bi and queer communities. This made it much easier for the child to understand what was happening given that "I'm just like so and so and I now use these pronouns" was all that was needed.

While this may seem too good to be true, not all partnerships go through turmoil when one person comes out. Queer partnerships, for example, may have a better chance to address these changes with community support and, depending on the identities of the people involved, with much more ease and no personal identity crisis. For example, it is important to consider that not all partnerships share an orientation and that many people in queer communities might be in mixed orientation partnerships before anyone transitions (e.g. a gay man partnered with a bi man). It is important to note this, especially when discussing children and parental transition processes and/or coming out. As family therapists, we know that parents are influential and set the tone for how children respond to external circumstances. Coming out as trans/nonbinary and/or undertaking social, legal and/or medical transition does not need to be traumatic or even challenging experiences for children. The ways in which not only the trans/nonbinary partner(s) respond but also how the cis partner(s) respond have significant impact on any children involved.

Cisgenderism Sadly, cisgenderism still has an impact on family systems in which coming out or having always been out as trans/nonbinary is not a big deal. To stay with the example of the child of one of the authors, when she was in elementary school, she asked for her peers and teachers to be educated about gender because she felt that she had to educate people around her. When the family met with the school's social worker to address this, the focus was quickly shifted to how the parent's transition had impacted the child. Even the teacher present was surprised and clearly stated this was not the issue given that the child was doing well academically and socially. The issue at hand was the lack of education and support in school and how that impacted the child. However, given the pervasive nature of cisgenderism, the social worker's assumption was that the issue resided with the family system and the transition process rather than the school system. Therapy can be no different if we are not careful. Once more, it is vital to ask ourselves which narratives we are centering and are we uncritically buying into tropes, stereotypes, and easy assumptions when working with family systems in which a parent is trans/nonbinary? Reflexivity is an essential part of this process. If we as therapists, regardless of our own gender identity, have not clearly and critically explored our relationship with gender, we cannot competently facilitate this process for the families who come to us for support. One of the tropes that we need to be particularly cautious of is that one parent coming out might be confusing for any children involved, especially younger children. There is no evidence to support this trope; rather, research has shown that families can become more resilient (Dierckx et al., 2017) and parental conflict is more distressing to children than disclosure and transition (Green, 2006). In fact, most people do not worry about their cis identity being known to children. If they have a cis identity, they do not think this might be confusing to children, or that it might unduly influence them to lean toward a cis identity. Most cis people also do not worry about exposure to gender stereotypes, which is unavoidable if a child interacts with the world around them. However, as soon as a parent comes out as trans and/or nonbinary, there seems to be concerns surrounding the child's capacity to grasp gender identity, a concept they have grasped well until that moment. Reflexivity can help us avoid tripping into our implicit bias when working with families where one or more persons are trans and/or nonbinary. Relational reflexivity (Burnham, 2005) can also help us check in with our clients to evaluate how our interventions are received. This can also support a more collaborative therapeutic approach.

Relationships between Transgender Partners

There is a dearth of literature on loving and being loved by a transgender person, and what does exist often centers and privileges cisgender partners and their reactions. Furthermore, there

is little written about transgender people who identify as lesbian, gay, bisexual, queer, or any other non-heterosexual identity. Although commonly characterized as tumultuous and grief-laden, awakening to one's gender while embodying a transcendental gendered experience is a significant step toward one's sense of personal sovereignty. This dismissal of institutionalized and *cis*-temic sameness comes with a plethora of rewards and tensions that can manifest within intimate partnerships.

Well-Being for Trans and Nonbinary Relationships

We identified crucial aspects of transgender and nonbinary relational well-being, which therapists should access in couple therapy. Elements of safety, self-care, stability, and social support contribute to basic needs in relationships.

Safety Due to incessant systemic and interpersonal discrimination, physical and emotional safety and well-being are a top relational priority. Transgender people, especially transgender people of color, are at higher risk of experiencing violence, as well as intimate partner violence that includes physical and sexual assault and financial abuse (James et al., 2015). In addition, it is possible that internalized transphobia can play a major part in these relationships (Rood et al., 2017). Internalized transphobia can manifest in a number of ways that cause couples to turn away from each other, taking out societal harm on each other. How would you help clients maintain a loving and compassionate self-image in the midst of societal oppression? A sense of safety in the world, within one's community, family, and self, greatly impacts relationship dynamics and satisfaction.

Self-Care Because transgender people often live with chronic sociopolitical trauma, relational work has to be trauma-informed, healing-centered, and focused on developing self-care practices that can ground trans people as they navigate their life. The impact of chronic interpersonal, intrapersonal, and institutional stressors increases the likelihood of escapism through risky health behaviors, substance abuse, and other covert methods of self-harm. Raj (2007) introduced the use of trans activism within therapeutic relationships as a method to self-care by learning to advocate for oneself as well as one's community, which requires positive self-identity and community identity. This model of "transactivist therapy-in-action" is a process that involves the therapist helping clients develop self-advocacy and community activism skills in an effort to re-channel "righteous rage" that results from experiences of ongoing discrimination. This also supports clients in developing a sense of agency, efficacy, and resilience, which, in turn, improves their quality of life (Raj, 2007). Cultivating agency, self-efficacy, resilience, and resolve activates the innate power within transgender couples and builds a transformative self-care practice that can help withstand the societal lag of acceptance.

Stability Due to disparities in access experienced by transgender people, it can be difficult to attain trans-affirming housing, find inclusive and competent health care providers, and trans-friendly employment. An imbalance within any of these necessities within a relationship can greatly impact all dynamics of intimate partnership. This imbalance is even greater for those who are undocumented or in the midst of navigating the immigration system, or for chronically ill and disabled trans people. As a clinician, how do you navigate the complexities of access on relational strain and distress?

Social Support Supporting and loving a transgender person is an act of resistance that, over time, can ripple through our colonized renderings of gender identity and expression. From communal isolation to family rejection, gender-expansive communities often lack the social

support networks needed to thrive. Through fictive kin, chosen family networks, and intimate relationships, transgender people queer and reimagine intimacy and connectedness. There is a significant decrease in chronic disease, psychiatric and physical morbidity, and mortality for individuals whose social networks provide adequate social support (Graham et al., 2014). As social networks provide a sense of belonging, security, stability, purpose, and worth, Graham et al. (2014) state that social support is characterized in two ways: (1) through provision of emotional, informational, or instrumental resources; and (2) by influencing cognition, emotions, and actions without explicitly aiming to help or support. In what ways can you advocate for trans folks and their partners to develop and maintain their close social circles?

Key Points

In an effort to invite therapists into increased accountability practices, we have included key points for therapists to consider when working with trans and nonbinary couples:

- Trust is essential to establish a strong therapeutic alliance, which can be more challenging to establish for cis therapist given the history of cisgenderism and transphobia in our field. Trust can also be challenging to establish for trans and/or nonbinary therapists as they might not be seen as competent as their cis counterparts due to issues of epistemic injustice.
- Reflective practices are vital. They can help us be more aware of our positioning with regard to gender and be vigilant of our own assumptions, gender stereotypes, and implicit bias. Reflective practices can help us avoid the danger of turning the therapy room into a mirrored room where we reflect back the same dominant culture discourses, rather than challenging them.
- Developing knowledge and competence in working with trans and/or nonbinary clients and relational dynamics is important. This also helps us avoid the trap of automatically centering cis narratives and the risk of reproducing cisgenderist and even transphobic tropes, which are harmful to the therapeutic process.
- Awareness that a rigid gender binary is part of the ongoing settler colonial project and, as such, cannot be looked at as an isolated phenomenon but rather as a facet of systemic oppression, which interlocks with other types of oppression, such as racism, ableism, and classism. Therapists can explore these influences with couples to help them determine what beliefs are imposed on them and what relational ethics they hold as a couple.
- Vigilance to avoid the ongoing pathologizing of trans and/or nonbinary identities by assuming that trans and/or nonbinary identities are challenging or even damaging to a family system. Further, partners may be attracted to trans and nonbinary people due to their authenticity, countering dominant couple distress assumptions.
- Maintain a spirit of collaboration and transdisciplinary curiosity. Doing intersectional work with gender-expansive communities requires a keen and constant awareness of the practitioners who work with your client. As a professional, you are able to work with health care providers to ensure trans-inclusive care for your clients.
- Develop your own self-care practices. For transgender and gender-non-conforming therapists, it is important to care for yourself while working within your community. Be mindful of compassion fatigue, vicarious/secondary trauma, multiple minority stress, and your own internalized oppression.

Suggested Reading

Barker, M. -J., & Iantaffi, A. (2019). *Life isn't binary: On being both, beyond, and in-between*. Jessica Kingsley Publishers.

DeBord, K. A., Fischer, A. R., Bieschke, K. J., & Perez, R. M. (2017). *Handbook of sexual orientation and gender diversity in counseling and psychotherapy.* American Psychological Association.

Iantaffi, A., & Barker, M. -J. (2018). *How to understand your gender: A practical guide for exploring who you are.* Jessica Kingsley Publishers.

Iantaffi, A., & Benson, K. E. (2018). Sex is for every body: Trans affirming sex therapy. In S. Greene & D. Flemons (Eds.), *Quickies: The handbook of brief sex therapy* (3rd ed., pp. 196–215). Norton.

Mccullough, R., Dispenza, F., Parker, L. K., Viehl, C. J., Chang, C. Y., & Murphy, T. M. (2017). The counseling experiences of transgender and gender nonconforming clients. *Journal of Counseling & Development, 95*(4), 423–434. https://doi.org/10.1002/jcad.12157

Mental health considerations with transgender and gender nonconforming clients. (2016, May 28). https://transcare.ucsf.edu/guidelines/mental-health

Singh, A. A., & Dickey, L. M. (2017). *Affirmative counseling and psychological practice with transgender and gender nonconforming clients.* American Psychological Association.

Spencer, K. G., Iantaffi, A., & Bockting, W. O. (2017). Treating sexual problems in transgender clients. In Z. D. Peterson (Ed.), *The Wiley handbook of sex therapy* (pp. 291–305). Wiley.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Association.

Ansara, Y. G., & Hegarty, P. (2012). Cisgenderism in psychology: Pathologizing and misgendering children from 1999 to 2008. *Psychology & Sexuality, 3*(2), 137–160. https://doi.org/10.1080/19419899.2011.576696

Associated Press. (2014, June 22). *Without fanfare, Obama advances transgender rights.* https://www.cbsnews.com/news/without-fanfare-obama-advances-transgender-rights/

Balsam, K. F., Molina, Y., Beadnell, B., Simoni, J., & Walters, K. (2011). Measuring multiple minority stress: The LGBT people of color microaggressions scale. *Cultural Diversity and Ethnic Minority Psychology, 17*(2), 163–174. https://doi.org/10.1037/a0023244

Barker, M. -J., & Iantaffi, A. (2019). *Life isn't binary: On being both, beyond, and in-between.* Jessica Kingsley Publishers.

Binaohan, B. (2014). *Decolonizing trans/gender 101.* Biyuti Publishing.

Blow, A. J., & Sprenkle, D. H. (2004). Common factors and our sacred models. *Journal of Marital and Family Therapy, 30*(2), 113–129. https://doi.org/10.1111/j.1752-0606.2004.tb01228.x

Blumer, M. L., Gavriel Ansara, Y., & Watson, C. M. (2013). Cisgenderism in family therapy: How everyday clinical practices can delegitimize people's gender self-designations. *Journal of Family Psychotherapy, 24*(4), 267–285. https://doi.org/10.1080/08975353.2013.849551

Brill, S., & Kenney, S. (2016). *The transgender teen: A handbook for parents and professionals supporting transgender and non-binary teens.* Cleis Press.

Burnham J. (2005). Relational reflexivity: A tool for socially constructing therapeutic relationships. In C. Flaskas, B. Mason, & A. Perlesz (Eds.), *The space between: Experience, context and process in the therapeutic relationship*. Karnac Books.

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum, 1*(8), 139–167. https://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8

Dierckx, M., Mortelmans, D., Motmans, J., & T'Sjoen, G. (2017). Resilience in families in transition: What happens when a parent is transgender? *Family Relations, 66*(3), 399–411. https://doi.org/10.1111/fare.12282

Duran, E. (2006). *Healing the soul wound: Counseling with American Indians and other Native peoples.* Teachers College Press.

Graham, L. F., Crissman, H. P., Tocco, J., Hughes, L. A., Snow, R. C., & Padilla, M. B. (2014). Interpersonal relationships and social support in transitioning narratives of Black transgender women in Detroit. *International Journal of Transgenderism, 15*(2), 100–113. https://doi.org/10.1080/15532739.2014.937042

Green, R. (2006). Parental alienation syndrome and the transsexual parent. *International Journal of Transgenderism, 9*(1), 9–13. https://doi.org/10.1300/J485v09n01_02

Hare-Mustin, R. T. (1994). Discourses in the mirrored room: A postmodern analysis of therapy. *Family Process, 33*(1), 19–35. https://doi.org/10.1111/j.1545-5300.1994.00019.x

Human Rights Campaign. (October 20, 2019). *Violence against the transgender community in 2019.* https://www.hrc.org/resources/violence-against-the-transgender-community-in-2019

Iantaffi, A., & Benson, K. E. (2018). Sex is for every body: Trans affirming sex therapy. In S. Greene & D. Flemons (Eds.), *Quickies: The handbook of brief sex therapy* (3rd ed., pp. 196–215). Norton.

James, S. E., Brown, C., & Wilson, I. (2015). *US transgender survey: Report on the experiences of Black respondents*. Washington, DC and Dallas, TX: National Center for Transgender Equality. Black Trans Advocacy, & National Black Justice Coalition. http://www.transequality.org/sites/default/files/docs/usts/USTSBlackRespondents Report-Rev1017.pdf

Lefevor, G. T., Janis, R. A., Franklin, A., & Stone, W. (2019). Distress and therapeutic outcomes among transgender and gender nonconforming people of color. *The Counseling Psychologist, 47*(1), 34–58. https://doi.org/10.1177/0011000019827210

National Center for Transgender Equality. (2019, May 31). *The discrimination administration.* https://transequality.org/the-discrimination-administration

Raj, R. (2007). Transactivism as therapy: A client self-empowerment model linking personal and social agency. *Journal of Gay & Lesbian Psychotherapy, 11*(3–4), 77–98. https://doi.org/10.1300/j236v11n03_05

Ring, T. (2019, June 27). These are the trans people killed in 2019. *The Advocate Magazine.* https://www.advocate.com/transgender/2019/5/22/these-are-trans-people-killed-2019#media-gallery-media-0

Rood, B. A., Reisner, S. L., Puckett, J. A., Surace, F. I., Berman, A. K., & Pantalone, D. W. (2017). Internalized transphobia: Exploring perceptions of social messages in transgender and gender-nonconforming adults. *International Journal of Transgenderism, 18*(4), 411–426. https://doi.org/10.1080/15532739.2017.1329048

Schulz, S. L. (2018). The informed consent model of transgender care: An alternative to the diagnosis of gender dysphoria. *Journal of Humanistic Psychology, 58*(1), 72–92. https://doi.org/10.1177/0022167817745217

Singh, A. A., Hwahng, S. J., Chang, S. C., & White, B. (2017). Affirmative counseling with trans/gender-variant people of color. In A. Singh & l. m. dickey (Eds.), *Perspectives on sexual orientation and diversity: Affirmative counseling and psychological practice with transgender and gender nonconforming clients* (pp. 41–68). American Psychological Association.

Singh, A. A., & McKleroy, V. S. (2011). "Just getting out of bed is a revolutionary act": The resilience of transgender people of color who have survived traumatic life events. *Traumatology, 17*(2), 34–44. https://doi.org/10.1177/1534765610369261

Steinmetz, K. (2014, May 29). *Laverne Cox Interview: Orange is the new black star on being trans.* https://time.com/132769/transgender-orange-is-the-new-black-laverne-cox-interview/

World Professional Association for Transgender Health. (September 16, 2019). *Ethical guidelines for professionals*. https://www.wpath.org/about/ethics-and-standards

8

Affirming Diversity and Targeting Pleasure

Sex Therapy for Gay Male Couples

MARIA MANUELA PEIXOTO

Background: Theory and Research

Literature on gay male couples' sexuality has found that common presenting concerns include relationship status (e.g. monogamy, non-monogamy, consensual open relationships; Spitalnick & McNair, 2005), HIV status (e.g. positive, negative, unknown; Beckerman, 2004; Mitchell, 2013), and issues of internalized homophobia and minority stress (Meyer, 1995; Williamson, 2000). Some research examines the similarities and differences between heterosexual couples and gay male couples (McWhirter & Mattison, 1978, 1980; Roisman et al., 2008). Nevertheless, although research regarding sex therapy for heterosexual men can be readily found (Frühauf et al., 2013), until recently, little research has been published with gay male couples addressing sexual dysfunctions.

In 2010, Hart and Schwartz presented two case studies of gay male couples affected by erectile dysfunction which provided a detailed cognitive-behavioral intervention. Cognitive-behavioral therapy addresses Erectile Disorders by targeting sexual beliefs, particularly expectations about sexual performance (Zilbergeld, 1999). A deeper analysis of the two case studies corroborates both similarities and differences between gay male and heterosexual couples. For instance, Hart and Schwartz (2010) identified sexual beliefs common to gay and heterosexual men (e.g. "I must always be ready for sex"), and acknowledged particular sexual beliefs associated with Erectile Disorder in gay male couples (e.g. "Gay men must be either the 'top' or the 'bottom'" or "A good 'top' is always erect during sexual encounters"). In this study, the cognitive-behavioral intervention for erectile dysfunction focused on managing anxiety about performance, and was successful according to client self-report about their perceived sexual functioning (Hart & Schwartz, 2010). Empirical support for the role of maladaptive sexual beliefs as vulnerability factors for sexual dysfunction in gay men was also found (Peixoto & Nobre, 2014, 2017). Still, a lack of empirical data about efficacy of sex therapy with gay male couples remains a major concern. Nonetheless, empirical studies about cognitive and emotional dimensions associated with sexual problems in gay male couples (Lacefield & Negy, 2012; Peixoto & Nobre, 2016a, 2017) support the hypothesis that cognitive-behavioral approaches may be extremely helpful.

From Classical Sex Therapy to Affirmative Sex Therapy with Same-Sex Couples

William Masters and Virginia Johnson (1966) pioneered research techniques designed to assess and better understand human sexuality. In their laboratory experiments, they studied the human sexual response primarily in heterosexual couples. Out of their experiments, a grounded model was established for male and female physiological sexual response. These foundational principles led to the development of classic sex therapy techniques that have been widely used in clinical work with heterosexual couples ever since (Masters & Johnson, 1970). Not well known, but relevant for this chapter, was their third book about sexual behavior patterns of gay men and

DOI: 10.4324/9780429274626-11

lesbian women in committed relationships (Masters & Johnson, 1979). According to interviews conducted in this pioneer comparative work, Masters and Johnson (1979, p. 73) acknowledged that "…committed male homosexual study subjects usually stated in essence that they stimulated their partners the way they (the stimulators) would like to be stimulated." Globally, the book enhanced the role of self-awareness and body-awareness as main factors predicting sexual and relationship satisfaction among same-sex committed couples, as well as highlighted healthy patterns of communication.

Back in the 1960s to 1980s, psychotherapy for gay men focused heavily on conversion therapies, or interventions designed to change sexual orientation, as homosexuality was considered a pathological medical condition. The majority of gay men seeking help for mental or health problems were referred by their own parents or families in order to receive conversion "treatments" designed to "fix" their homosexuality (Ussher, 1990a). However, over time, psychotherapists and sex therapists began working with gay men and couples whose presenting concerns were not about their own sexual orientation but about concerns related to their intimate and committed relationships.

Classical sex therapy strategies began to be used with gay men in the 1980s (Paff, 1985). Reece (1982) reported using assessment strategies and clinical interventions adapted from sex therapy models which yielded 93% success rate at the end of the treatment, and an 83% success rate at a six-month follow-up. Reese extended this work in 1987 by specifically utilizing sensate focus for gay couples in sex therapy (Reece, 1987). Nonetheless, despite some anecdotal case studies (Garippa & Sanders, 1997; Hart & Schwartz, 2010), no empirical data assessing clinical efficacy of sex therapy with gay male couples has been conducted.

An Affirmative Psychotherapeutic Approach

One of the first published works addressing sexual dysfunction in gay male couples was by McWhirter and Mattison (1978, 1980), who used anecdotal presentation of case studies to summarize the similarities and differences between gay male and heterosexual couples seeking help for sexual concerns. McWhirter and Mattison (1978, 1980) identified several main similarities between gay male and heterosexual couples seeking sex therapy. These include communication difficulties (including lack of assertiveness), inability to acknowledge one's own relationship needs, the spectatoring phenomenon (when the individual focuses on and intrusively monitors his own sexual performance during sex; Masters & Johnson, 1970), disparate levels of sexual desire, and the comorbidity between sexual dysfunction and other mental disorders. Although both gay male and heterosexual couples reported believing in myths about sexual response or a lack of knowledge about human anatomy and sexual physiology, these issues were more prevalent and problematic among heterosexual couples (McWhirter & Mattison, 1978, 1980). This finding was consistent with Masters and Johnson's (1979) previous work, which found that gay men's sexuality was advanced and supported by their familiarity, comfort, and awareness of their own body which helped them during sexual interactions as they implicitly understand their partner's bodies more than an opposite sexed partner might.

There were some important differences found between the experience of gay male couples and heterosexual couples, for which affirmative therapists must attend. First, open and/or non-monogamous relationships are more common among gay men and not uniformly considered an obstacle for lasting and satisfied relationships (Ramirez & Brown, 2010). Relatedly, gay male couples are less constrained by traditional and cultural sexual scripts. They appear to have fewer rigid rules regarding sexual attitudes and beliefs, and a tendency to flexibly adopt non-traditional cultural and gender roles (McWhirter & Mattison, 1978, 1980). Another particularity is deeper empathy and less blaming between partners within the context of a sexual dysfunction, which may be due to familiarity and understanding of male anatomy and physiology,

and, consequently, a decreased likelihood of blaming the partner for a persistent sexual problem (McWhirter & Mattison, 1978, 1980). Additionally, gay couples are more likely than their heterosexual counterparts to have limited or absent social supports in a variety of contexts, including familial, community, and institutional support. The lack of social support is still common and is connected with increased comorbid health problems, including those which can complicate sexual functioning. Moreover, McWhirter and Mattison (1978, 1980) found that having sexual difficulties may lead to relationship termination for gay men.

The therapeutic alliance has been shown to be connected to the effectiveness of psychotherapy (Lambert, 2013), and sex therapy is no different. Therapist's ability to build an alliance has been considered fundamental for good outcomes in psychotherapy. The intersectionality approach is an important framework to take into consideration for sex therapy with gay male couples as the therapist's ability to be informed and aware of clients' context and social culture has been shown to support successful outcomes in therapy (Adames et al., 2018).

Affirmative therapy for gay male couples is marked by intersectional interventions which take into consideration the specificities of the gay male community using an inclusive and acceptance-based approach (Rutter, 2012) while considering the multiple experiences of marginalization that can affect gay men. Intersectionality is a therapeutic approach whereby affirmative therapists collaboratively guide gay men to better understand how oppression due to sexual orientation, gender identity, and race (among other identities) negatively affects their personal lives, including their sexuality (Adames et al., 2018). Once recognized, the negative influence of these dominant stories can be neutralized. Gay men can re-write their own narrative through a deeper comprehension of their unique experiences and particularities.

If heterosexual couples follow a previously established sexual and marital script, gay male couples have to create their own relational scripts which may include the possibility of marriage, managing the threat of HIV/AIDS, and non-exclusive relationships (Rutter, 2012). Sex therapists need to be aware of the variety of possible scripts that their clients may adopt. Exhibiting an affirmative approach to clients can be a significant challenge for professionals especially if they are cisgender and heterosexual. Although all people go through a sexual developmental process, heterosexual development often supports dominant notions of sex and gender roles and sometimes results to the idea that heterosexual sexual orientation has more value compared to other sexual orientations (Matthews, 2007). Heterosexism can (overtly and covertly) have a negative impact on the therapeutic relationship, while an open and affirming counseling stance may lead to better therapeutic outcomes. Therefore, therapists who work with gay male couples must have theoretical knowledge, practical background, and opportunities to assess their assumptions and values about sexual minority experience, in order to provide appropriate support, demonstrate an empathic comprehension of the difficulties of intersectional oppression, and be able to recommend support groups or other associations that may help the individual or the couple to emerge in the local gay community (Gordon, 1986; MacDonald, 1998; McWhirter & Mattison, 1982; Spitalnick & McNair, 2005).

A Cognitive-Emotional Approach

Alongside a general affirmative framework with gay male couples, therapists might use a cognitive-emotional approach as outlined by Nobre (2013); this approach has some preliminary empirical evidence of effectiveness for sexual dysfunction in gay male couples. According to the Cognitive-Emotional Model of Sexual Dysfunction by Nobre (2013), personality traits and sexual beliefs are factors that either provide protective mechanisms against or increase the likelihood of sexual dysfunction. Negative beliefs about self or other can be predispositional factors so that when unsuccessful or unsatisfactory sexual encounters occur, a cognitive schema of incompetence or hopelessness can be activated promoting a rush of negative automatic thoughts

and negative emotions during subsequent sexual experiences. Studies have found that this theoretical model is supported by empirical evidence with both heterosexual samples and now also with samples of gay men (Peixoto & Nobre, 2014, 2016a, 2017). Neurotic personality traits and conservative sexual beliefs appear to work as factors that increase sexual distress and sexual problems in gay men (Peixoto & Nobre, 2014, 2016b). During sexual encounters, when sexual problems arise, a decrease in erotic thoughts and an increase in negative automatic thoughts are observed. This is consistent with data from heterosexual samples. Automatic thoughts anticipating failures in erection are particularly observed in gay men (Peixoto & Nobre, 2016a). This then led to the development and activation of negative cognitive schemas, such as undesirability/rejection and difference/loneliness for gay men (Peixoto & Nobre, 2015).

Cognitive Restructuring

During clinical assessment, the therapist would assess negative automatic thoughts, such as "if I don't have an erection, my partner will leave me." It will be helpful to use self-monitoring tools, such as tables where the men should write down their automatic thoughts, how much they believe in the thought, emotions experienced, and what their resulting behavior was. After using guided imagery, the therapist should help the client be aware of cognitive errors such as catastrophizing or all-or-nothing thinking. Challenges to cognitive errors such as these can be pursued in individual sessions as well as couple sessions where the presence of the other partner gives the therapist the opportunity to explore directly with the couple how erectile difficulties will affect their relationship. Will it mean as one partner fears that "my partner will no longer be committed" or that he "won't love me anymore?" Couple sessions allow these insecurities to be openly addressed.

Sexual Difficulties and Gay Male Couples

According to the Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5; American Psychiatric Association, 2013), sexual dysfunctions are characterized by difficulties associated with phases of the sexual response cycle, namely sexual desire, sexual arousal, and orgasm/resolution phases. Additionally, the current edition of the DSM-5 (American Psychiatric Association, 2013) states that difficulties must persist over six months, and must be associated with clinical distress. Male sexual dysfunctions include Hypoactive Sexual Desire Disorder, Erectile Disorder, Delayed Ejaculation, and Premature Ejaculation. Sexual difficulties and sexual problems may also be associated with sexual desire, sexual arousal, and orgasm/resolution phases, but were less severe or have no associated distress. Thus, sexual presence and extent of distress is a major dimension to consider in the clinical assessment of sex therapy. Other variants of difficulties related to sexual desire, such as sexual desire discrepancies, were also considered a sexual problem but do not constitute a sexual dysfunction. Clinical cases describing sexual desire discrepancies among gay male couples are very similar to reports of discrepancies of desire among heterosexual couples (Reece, 1987). In addition to the factors usually mentioned in the literature regarding sexual desire problems, gay male couples also contend with internalized homonegativity which can contribute to the lack of desire to engage in a sexual activity with a partner (Reece, 1987).

DSM Diagnoses for Male Sexual Dysfunctions

As mentioned above, male sexual dysfunctions, as defined by the DSM-5 (American Psychiatric Association, 2013), are Hypoactive Sexual Desire Disorder for the sexual desire phase; Erectile Disorder for the sexual arousal phase; and Delayed Ejaculation and Premature Ejaculation for the orgasmic phase.

Hypoactive Sexual Desire Disorder is characterized by a persistent and recurrent diminishment or absence of sexual and erotic thoughts, sexual fantasies, and desire, interest, and drive to engage in a sexual activity alone or with a partner. Erectile Disorder is defined by a persistent

inability or difficulty in achieving an erection, or a persistent inability or difficulty in maintaining an erection adequate for sexual activity, and/or a marked decrease in erectile rigidity during sexual activities. Delayed Ejaculation occurs when, despite adequate sexual stimulation, proper sexual arousal, and presence of sexual desire, a man has a persistent difficulty or even total inability to achieve orgasm and ejaculate. Finally, Premature Ejaculation is characterized by a persistent and recurrent pattern of ejaculation, either prior to or within one minute after (vaginal) penetration, or any time before a man wishes it. Until 2013, no other sexual activities besides vaginal penetration were considerations for a proper clinical diagnosis of Premature Ejaculation. For obvious reasons, this clinical diagnosis was highly criticized as clearly discriminatory against men who have sex with men or even heterosexual men who did not engage in vaginal penetration intercourse (Althof et al., 2014; Serefoglu & Saitz, 2012). Currently, the DSM-5 (American Psychiatric Association, 2013) allows for other nonvaginal penetration activities to be considered when diagnosing Premature Ejaculation; however, specific duration criteria have not been established yet. According to previous studies, diversity of sexual behaviors observed across sexual orientation has a little impact on ejaculatory function, with no significant differences found between gay and heterosexual men regarding Premature Ejaculation (Breyer et al., 2010; Jern et al., 2010).

Discrepancy in Sexual Desire

Discrepancies in sexual desire are also a common presenting problem for gay male couples. This is described as a difference between partners' sexual desire and interest in engaging in sexual activities within an intimate relationship (Zilbergeld & Ellison, 1980). As with all other sexual difficulties and problems, sexual desire discrepancy has been extensively studied within heterosexual relationships, suggesting that sexual desire discrepancies negatively impact both sexual and relationship satisfaction (Davies et al., 1999; Mark, 2012, 2014, 2015; Mark & Murray, 2012; Willoughby & Vitas, 2012). A relevant concern recently raised by Bridges and Horne (2007) was the perception of how problematic sexual desire discrepancies were. These authors studied the role of problematic and non-problematic sexual desire discrepancy in lesbian couples and found that when the discrepancy was not perceived as problematic, little or no impact was found in sexual and relationship satisfaction for lesbian women (Bridges & Horne, 2007). The same hypothesis was recently tested with gay men, and results suggested a similar pattern for gay male couples (Pereira et al., 2019). Specifically, gay men who experienced no sexual desire discrepancy were more satisfied with their sex life and with their intimate relationship compared to gay men who perceived some degree of sexual desire discrepancy, whether the discrepancy was regarded as being problematic or non-problematic. Similar to the study by Bridges and Horne (2007), gay men who did not define their sexual desire discrepancy as problematic were more satisfied sexually and with their intimate relationships than gay men who perceived the discrepancy as problematic (Pereira et al., 2019). Once again, the individual's perception of sexual difficulties is of utmost importance for health care professionals to assess.

Anodyspareunia (Pain during Anal Sex)

One of the most common sexual complaints for gay male couples is *anodyspareunia* (Rosser et al., 1998). Until 2013, dyspareunia could be diagnosed in men and women who complain about pain during sexual activity. Since the publication of the DSM-5 (American Psychiatric Association, 2013), dyspareunia was removed from the male sexual dysfunctions section. When approaching the topic of sexual pain in gay male couples, clinicians may find Damon and Rosser's (2005) conceptualization of *anodyspareunia* helpful; anodyspareunia refers to complains about sexual pain during anal sex.

Rosser and colleagues (1997) found that 61% of men who have sex with men complained about feeling sexual pain during anal sex. This finding led to a set of empirical studies that focused on

analyzing frequency and severity levels of pain that gay men experience during anal intercourse. Initially, data indicated that at least 63% of men who have sex with men experience mild to moderate and occasional pain, whereas 12% experience extreme severe and persistent pain during receptive anal intercourse (Rosser et al., 1998). Characteristics associated with receptive painful anal intercourse were inadequate lubrication, higher levels of anxiety during sexual activity, lack of or inadequate stimulation prior to penetration, partner's penis size, and lower sexual arousal (Rosser et al., 1998). Later, Damon and Rosser (2005) attempted to study *anodyspareunia* from a clinical diagnosis point of view, and attempted to establish both behavioral and clinical criteria. Behavioral criteria are based on frequency and severity levels of sexual pain, while clinical criteria focus on whether pain during sex causes distress and interpersonal difficulties. In addition, clinical criterion explores how factors like inadequate lubrication and sexual stimulation, medical conditions, and/or the use of drugs is associated with painful anal intercourse (Damon & Rosser, 2005). In this study, 14% of men who engage in receptive anal intercourse met a criterion for behavioral painful sex, while 10% met clinical criteria; 21% of men reported that this problem was lifelong for them, and 60% perceived it as problematic. A quarter of the sample experienced painful anal sex with severe distress and almost 20% described extreme interpersonal consequences and difficulties as a result. Consequently, more than 80% avoid this particular sexual activity for a period of time, and half of the men switch from a receptive role to a penetrative role with their sexual partners (Damon & Rosser, 2005).

In addressing sexual pain in gay male couples, it is important to discuss common vernacular used in gay culture to distinguish sex roles that gay men, who engage in anal intercourse, may adopt, such as "top," "bottom," or "versatile" (Damon, 2000; Gil, 2007; Hart et al., 2003; Moskowitz et al., 2008). Gay men who usually engage in receptive sexual behavior, and are anally penetrated by their sexual partners, are labeled as "bottom," whereas gay men who frequently engage in penetrative sexual behavior, and frequently penetrate their partners sexually during anal sex, are labeled as "top." Gay men who take on both sex roles are considered and labeled "versatile." The role adopted during sexual activities is relevant for many gay male couples, although not all. Hart et al. (2003) found that the sexual labels gay men assigned to themselves often accurately predicted the types of sexual and intimate acts they participated in. Those who thought of themselves as "bottoms" tend to prefer a more submissive, accommodating position in intimate relationships, whereas gay men who consider themselves "tops" usually prefer sexual and intimate relationships where they felt in control and dominant (Damon, 2000).

It is important to assess the use of these roles and labels for gay male clients (Bettinger, 2004) for the ways they are meaningful and constructive in their lives as well as the ways these narratives can become rigidified and not useful in their intimate partnerships.

Sex Therapy with Gay Male Couples

It is my view that classic sex therapy strategies coupled with an affirmative approach are well suited for gay male couples who seek therapy. Sex therapy on its own would not readily address the specific intersectional factors for gay men experiencing sexual difficulties. An affirmative stance would better assess how gay men are uniquely impacted by social supports and internalized heterosexism, homonegativity and sexuality, HIV status, and the role of pleasure during sex as these are relevant dimensions that interfere in sex therapy with gay male couples.

Social Supports and Internalized Heterosexism

Gay male couples who seek help for their sexual and relationship problems embrace their relationships as serious and committed (Bepko & Johnson, 2000). Unfortunately, several countries around the world still criminalize homosexuality and others do not recognize legal civil unions or marriages for same-sex couples. For gay male couples living in these countries, lack of social support is

a constant worry, and seeking professional help forces them to come out to the therapist (Bepko & Johnson, 2000). The gay community can offer protection from heterosexism. When these communities are vibrant, they can provide gay men with a sociocultural context where they feel a sense of belonging and a place to share their concerns, feelings, and opportunities to socialize (Haldeman, 2007). However, there are several factors which might interfere with gay men actively identifying and connecting with a larger gay community. These include their own internalized homophobia, a lack of openly gay social supports or contexts, lack of group awareness or identification (Haldeman, 2007), as well as bias within the gay community itself such as racism, classism, etc.

When working with gay male couples, therapists need to be aware that they may have internalized heterosexist notions about their own sexual orientation. Gay men may present with negative misconceptions about themselves and their sexuality; for example, they may believe the common cognitive distortion that same-sex unions are less stable or inferior to heterosexual ones (Purcell et al., 1996) which may directly affect the choices they make in their relationships.

Besides these homonegative feelings, gay male couples also face the effects of the gender role socialization process. Gay men—like all men—have been raised with pervasive rewards for acting and behaving as a man with harsh consequences for not doing so (Bettinger, 2004; Connolly, 2004; Murphy, 1994). Dominant narratives about men's sexuality include the idea that men are more sexual and less emotional, and ought to be sexually tireless, sexually focused, and the active sexual partner in a relationship. These ideas are inculcated in all boys and men, including heterosexual men and gay men.

Health care professionals working clinically with gay male couples, in the context of sex therapy, should be particularly sensitive to these phenomena (Connolly, 2004; Murphy, 1994). Gay male couples objectively differ from heterosexual ones, as both members of the couple are men and most often share the same process of gender role socialization (Murphy, 1994).

Homonegativity and Sexuality

In addition to negative automatic thoughts related to sexual episodes, some gay men also reported negative automatic thoughts and attitudes toward homosexuality. During guided visualizations, the therapist can help gay men identify and explore the thoughts and the content which lead to this discomfort.

Therapist: Please, if you are comfortable, close your eyes, and think about the last time you had a sexual or intimate encounter with your partner. What did your senses tell you? What did you see, or hear? How was the temperature of the room? Did you note a special smell?

Client: Ok, I'll give it a try…

Therapist: Please let your thoughts come up and start noticing them as clouds. Can you identify some of them and say it out loud?

Client: Hmm…I guess… I think I cannot fail again, it will be terrible, he probably will leave me for good.

Therapist: Hmm, that must feel uncomfortable and scary. Can you stay with that thought and see if other thoughts appear?

Client: I guess…(pause) *sometimes I felt that there's something wrong, that I shouldn't be doing this, that is wrong, I don't know* (almost crying).

Therapist: Hmm, I can imagine how hurtful that might be experiencing that feeling. You may now open your eyes and take a deep breath. Sounds like you are experiencing negative attitudes towards yourself. I wonder to what extent these are inspired by your past experiences in childhood and perhaps in your religious beliefs. What would you like to say to yourself, during the moments when are you suffering? Can you use your "kind voice" as we have already addressed last session, for reassuring yourself?

Relationship Status

Historically, gay men have limited couples as role models who they might imitate, and instead may reinvent their own couples' dynamic (MacDonald, 1998; McWhirter & Mattison, 1982; Murphy, 1994; Spitalnick & McNair, 2005). Additionally, gay men tend to check their sexual compatibility before they start a lasting and committed relationship (Bettinger, 2004). Although gay male couples tend to be emotionally monogamous, they are not always sexually monogamous; they handle non-monogamy differently compared to heterosexual couples. This does not mean that romantic relationships between gay men lack intimacy or commitment (Bettinger, 2004). Indeed, no differences in sexual or relationship satisfaction have been found between gay male couples who are exclusive or non-exclusive (Blasband & Peplau, 1985; LaSala, 2004, 2005).

Affirmative sex therapists must clarify how gay couples understand and express their commitment to one another. This includes identifying specific sexual scenarios or behaviors each member considers a violation of their commitment to one another (Shernoff, 2006). It is extremely important for therapists to discern with clients the difference between infidelity and consensual non-monogamy, despite their own beliefs about relationship status and fidelity (Martell & Prince, 2005). Affirmative therapists should be prepared to explore in detail with couples how they establish, define, and evolve any (non)monogamous agreement (Shernoff, 2006) they make.

HIV Status

Safer sex practices are a part of sex therapy with all couples. For gay men who have differing HIV statuses, it can be a particular concern. For HIV+ partners, HIV treatment often includes antiretroviral medication associated with an increased risk for developing sexual dysfunction (Colson et al., 2002; Cove & Petrak, 2004). HIV-negative gay men report significantly fewer complaints related to sexual functioning (Mao et al., 2009; Shindel et al., 2012), and report more sexual interest and better erectile functioning when compared to HIV-positive gay men (Bancroft et al., 2005; Cove & Petrak, 2004; Meyer-Bahlburg et al., 1991; Vansintejan et al., 2013). These studies could not clearly conclude whether higher prevalence of sexual difficulties reported by HIV-positive gay men are a direct consequence of their clinical condition or rather a moderating factor, for example HIV-positive gay men report higher psychological maladjustment and clinical depression (Cove & Petrak, 2004), which increase vulnerability for sexual dysfunction, including erectile difficulties and a loss of interest in sex (Cove & Petrak, 2004; Meyer-Bahlburg et al., 1991).

Sexual risk taking or refusal to use condoms in the context of sexual intercourse among gay male couples is a relevant concern. Rationalizations and beliefs about HIV/AIDS, about sexual risk taking, sexual safety behaviors, or condom use must be thoroughly assessed in sex therapy contexts (Shernoff, 2005). When gay male couples are aware of being in a serodiscordant relationship, i.e. one member is HIV-positive and the other member is HIV-negative, sexual encounters maybe more fraught. This tension can be eroticized in some couples just as easily as it can extinguish desire in others. According to Ussher (1990b), a cognitive-behavioral couples therapy protocol for gay male couples with AIDS showed significant improvement in relationship satisfaction levels, empathy, and better communication.

Addressing Sexual Pleasure in Gay Male Couples

Similar to heterosexual couples, gay male couples who report being sexually satisfied also report an absence of sexual dysfunction (Carvalheira & Costa, 2015). However, sexual satisfaction is not just an absence of a sexual dysfunction. A qualitative study approaching lay people's understanding of the concept of sexual satisfaction with an LGB sample suggested that similar to previous heterosexual data, sexual satisfaction is a complex and multidimensional experience,

involving both inter- and intrapersonal dimensions (Pascoal et al., 2019). Therefore, sex therapy with gay male couples should target the treatment of sexual dysfunctions, including physical sensations and cognitions while also addressing the client's feelings, emotions, intersectional identity and dimensions, and dyadic and relationship processes (Pascoal et al., 2019).

Case Vignette

Juan, 34 years old, and Adam, 43 years old, have been together for seven years, in a committed and non-exclusive relationship. Juan has a Latino cultural background and a Catholic-based education, whereas Adam has a non-religious background and education. Adam has previous experiences with women; he has been married for two years, and has a 19-year-old son. He had a complicated coming out path initially due to lack of social and familial support. Currently, his family is supportive of him and his partner. Juan has always understood himself as gay, but also had a lack of social and familial support. His family continues to criticize him and persuade him to attempt conversion therapy. He has refused conversion therapy and decided to not be in contact with his family for now. Juan has 12 years of formal education and works as a sales assistant, while Adam has a Master's degree in Economics and works in an international finance company. They sought an appointment for sex therapy in order to deal with sexual desire discrepancies. Juan has been uninterested in Adam's attempts to engage in sexual intimacy for over six months, leaving Adam feeling rejected and isolated. In the past, they would occasionally meet other men in social clubs and discos and invite them to participate with them sexually. However, Juan has also not been interested in that type of sexual engagement either. No medical conditions are present and Juan did not met criteria for clinical depression. They are both HIV-negative. Juan tends to adopt a "top" sex role, whereas Adam tends to adopt a "bottom" sex role. Until a year ago, they described a satisfactory sexual life, with a daily engagement in sexual intimacy. Recently, Adam proposed to Juan, asking him to participate in a civil union with him.

Suggestions for Clinical Assessment

During initial clinical assessment for sex therapy, a therapist should clarify the main goal(s) of each member of the couple for therapy as well as additional couple goals that may be separate and distinct. Assessing sexual beliefs and sex education guidelines is of utmost importance during a clinical assessment (see Hart & Schwartz, 2010; Peixoto & Nobre, 2014 for examples of assessments about sexual beliefs). Likewise, it is relevant to assess gender role socialization, preferred sexual scripts, and sexual role models. Differences in power and identity should be explored, including the couples and individuals' narratives about how important decisions get made, who generally takes on the role of deciding, and whether the emotional labor of the relationship is equally distributed and respected. Different cultural and educational identities and backgrounds as well as class differences and professional careers should be addressed for what they communicate about the process of power in the relationship. And in this present example, it is important to take into consideration that a civil union was referred to and to explore how and under what circumstances that came about.

Related to sexual desire issues, it is important to consider external and contextual factors that may affect sexual interest, motivation, and desire, such as professional stress, familial concerns, or other psychological maladjustment. Additionally, considering that Juan tends to adopt a "top" sex role, it is important to clarify if he is experiencing sexual performance anxiety or any other erectile concerns or worries about satisfying his partner that may fuel the avoidance of sexual engagement and diminish his sexual interest and desire. Finally, previously attempted strategies to deal with this sexual problem should be assessed in order to clarify what has been tried and what has or has not helped.

Therapist: I would like now to evaluate beliefs about sexuality. We all have beliefs usually learned throughout our development. They are statements and rules about what we believe is right or wrong about human sexuality. I have a list of statements about your beliefs that I would like both of you to answer separately.

Clients: Hmm, ok. I guess we are very open minded about sex.

(After Juan and Adam answer the questionnaire about sexual beliefs, the therapist resumes the session interview).

Therapist: Juan, what would happen if you failed to achieve an erection and could not penetrate your partner?

Juan: (looks down) That would be horrible, Adam would leave me for good, and he has a really good job and every day interacts with attractive, powerful gay men. I imagine these men could give him all the sexual pleasure he deserves… it would be horrible.

Therapist: Hmm…I see. I understand that imagining that scenario makes you feel uncomfortable and sad. I can relate with that. Juan, would you leave him for good, if he occasionally had poor sexual performance?

Juan: No, I would never leave him for that, it could happen and that does not mean he's a bad partner. But then again, I'm just a sales assistant. Part of what I bring to this relationship is my sexual prowess.

Therapist: Can we hear what Adam has to say about that?

Clients: (both nod).

Therapist: Adam, Juan is thinking that the main way he contributes to the relationship is through his sexual capacity. What do you think?

Adam: I love Juan for so many other reasons in addition to the fact that he is an amazing lover. You asked if I would leave him if he sometimes could not get hard enough for penetration. I would never leave him for that. Sexual penetration is just one of many sexual activities we can have during a sexual encounter. And I know sometimes Juan is really tired at night due to his job.

Suggestions for Clinical Intervention

There are two main approaches for this clinical case—a behavioral approach and a cognitive approach. As mentioned earlier, sex therapy strategies such as sensate focus have been proposed and revealed positive outcomes with gay male couples. Therefore, it could be helpful to use a sensate focused intervention in order to promote pleasure as the couple's goal as well as increased intimacy between Juan and Adam. This might help to deemphasize penetration and decrease the sexual performance anxiety Juan is experiencing. Additionally, a cognitive perspective could be useful to promote sexual fantasies, erotic, and sexual thoughts that may promote sexual desire. Also, a playful discussion mediated by the therapist about sexual beliefs, myths, scripts, sexual roles, and gender role socialization could also be beneficial for both Juan and Adam. Communication skills should also be improved.

Therapist: I would like to propose a set of therapeutic exercises whose effectiveness is supported by empirical evidence in the treatment of sexual problems such as the one you are experiencing. It's called sensate focus and it promotes intimacy and demands both of you to focus on sexual experience from the point of you of your five senses. This first task will involve both of you touching each other, at separate times, in a mindful way without touching the genital areas. The intention is not to arouse one another or to have sex but rather to focus on giving and receiving pleasure. You can give each other a bath, a massage with oils or lotions, and share cuddles. It will be expected that you repeat this exercise at least three times a week for 30 minutes. After doing the exercise you should talk to each other about your feelings during the experience. Is that ok for both of you?

Juan: Hmm…I guess. But why we can't touch each other's genitals? I'm not following…
Therapist: The main goal is to reduce the focus on your erectile performance. It's an exercise to promote intimacy, closeness, pleasure and positive experiences.
Juan: Ok, I think we can try…I would really like that
Adam: Yeah, I guess we can try.
Therapist: Good to hear that both of you are able to give it a try.

Conclusions and Future Directions

There is a lack of empirical research in the area of sex therapy for gay male couples. An expanded comprehension of gay men's sexuality is optimal for affirmative therapy, and research should be done to support this work. Anecdotal evidence and case studies have been reported and, so far, support the role of cognitive-behavioral sex therapy for gay male couples (Hart & Schwartz, 2010). Addressing sex beliefs, gender role socialization, and sexual scripts is important when conducting sex therapy with gay men, and a positive and affirmative attitude from health care professionals is recommended. Relationship and HIV status are of utmost importance for gay male couples, as well as assess sex roles during sexual activities and behaviors. Relationship satisfaction, communication skills, and sexual pleasure should all be a target for sex therapy with gay male couples. Overall, the therapist must adopt an affirmative and supportive attitude, and should have a solid understanding of sexual minorities. Nonetheless, further empirical research is needed in order to replicate prevalence data about sexual dysfunction and develop assessment tools for men who have sex with men. Current findings on cognitive-emotional comprehensive approach for sexual dysfunction in gay men also need to be replicated and extended to other countries. Finally, it is urgent to empirically assess the efficacy of specific intervention protocols for gay male couples in order to establish guidelines and sex therapy manuals for gay men facing distressing sexual difficulties.

References

Adames, H. Y., Chavez-Dueñas, N. Y., Sharma, S., & La Roche, M. J. (2018). Intersectionality in psychotherapy: The experiences of an AfroLatinx queer immigrant. *Psychotherapy, 55*(1), 73–79. https://doi.org/10.1037/pst0000152

Althof, S. E., McMahon, C. G., Waldinger, M. D., Serefoglu, E. C., Shindel, A. W., Adaikan, P. G., Becher, E., Dean, J., Giuliano, F., Hellstrom, W. J. G., Giraldi, A., Glina, S., Incrocci, L., Jannini, E., McCabe, M., Parish, S., Rowland, D., Segraves, R.T., Sharlip, I., & Torres, L. O. (2014). An update of the International Society of Sexual Medicine's guidelines for the diagnosis and treatment of premature ejaculation (PE). *Sexual Medicine, 2*(2), 60–90.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Association. https://doi.org/10.1176/appi.books.9780890425596

Bancroft, J., Carnes, L., Janssen, E., Goodrich, D., & Long, J. S. (2005). Erectile and ejaculatory problems in gay and heterosexual men. *Archives of Sexual Behavior, 34*(3), 285–97. https://doi.org/10.1007/s10508-005-3117-7

Beckerman, N. L. (2004). Couples coping with discordant HIV status. *AIDS Patient Care and STDs, 16*(2), 55–59. https://doi.org/10.1089/10872910252806090

Bepko, C., & Johnson, T. (2000). Gay and lesbian couples in therapy: perspectives for the contemporary family therapist. *Journal of Marital and Family Therapy, 26*(4), 409–419. https://doi.org/10.1111/j.1752-0606.2000.tb00312.x

Bettinger, M. (2004). A systems approach to sex therapy with gay male couples. *Journal of Couple & Relationship Therapy, 3*(2–3), 65–74. https://doi.org/10.1300/J398v03n02_07

Blasband, D., & Peplau, L. (1985). Sexual exclusivity versus openness in gay male couples. *Archives of Sexual Behavior, 14*(5), 395–412. https://doi.org/10.1007/BF01542001

Breyer, B. N., Smith, J. F., Eisenberg, M. L., Ando, K. A., Rowen, T. S., Shindel, A. W. (2010). The impact of sexual orientation on sexuality and sexual practices in North American medical students. *Journal of Sexual Medicine, 7*(7), 2391–2400. https://doi.org/10.1111/j.1743-6109.2010.01794.x

Bridges, S. K., & Horne, S. G. (2007). Sexual satisfaction and desire discrepancy in same sex women's relationships. *Journal of Sex & Marital Therapy, 33*(1), 41–53. https://doi.org/10.1080/00926230600998466

Carvalheira, A. A., & Costa, P. A. (2015). The impact of relational factors on sexual satisfaction among heterosexual and homosexual men. *Sexual and Relationship Therapy, 30*(3), 314–324. https://doi.org/10.1080/14681994.2015.1041372

Colson, A. E., Keller, M. J., Sax, P. E., Pettus, P. T., Platt, R., & Choo, P. W. (2002). Male sexual dysfunction associated with antiretroviral therapy. *Journal of Acquired Immune Deficiency Syndromes, 30*(1), 27–32. https://doi.org/10.1097/00042560-200205010-00004

Connolly, C. M. (2004). Clinical issues with same-sex couples. *Journal of Couple & Relationship Therapy, 3*(2–3), 3–12. https://doi.org/10.1300/J398v03n02_02

Cove, J., & Petrak, J. (2004). Factors associated with sexual problems in HIV-positive gay men. *International Journal of STD & AIDS, 15*(11), 732–736. https://doi.org/10.1258/0956462042395221

Damon, W. (2000). The relations of power and intimacy motives to genito-erotic role preferences in gay men: A pilot study. *The Canadian Journal of Human Sexuality, 9*(1), 15–29.

Damon, W., & Rosser, B. R. (2005). Anodyspareunia in men who have sex with men: prevalence, predictors, consequences and the development of DSM diagnostic criteria. *Journal of Sex and Marital Therapy, 31*(2), 129–141. https://doi.org/10.1080/00926230590477989

Davies, S., Katz, J., & Jackson, J. L. (1999). Sexual desire discrepancies: Effects on sexual and relationship satisfaction in heterosexual dating couples. *Archives of Sexual Behavior, 28*(6), 553–567. https://doi.org/10.1023/A:1018721417683

Frühauf, S., Gerger, H., Munder, T., Schmidt, H., & Barth, J. (2013). Efficacy of psychological interventions for sexual dysfunctions: A systematic review and meta-analysis. *Archives of Sexual Behavior, 42*(6), 15–33. https://doi.org/10.1007/s10508-012-0062-0

Garippa, P. A., & Sanders, N. (1997). Resolution of erectile dysfunction and inhibited male orgasm in a single homosexual male and transfer of inhibited male orgasm cure to his partner: A case report. *Journal of Sex & Marital Therapy, 23*(2), 126–130. https://doi.org/10.1080/00926239708405313

Gil, S. (2007). A narrative exploration of gay men's sexual practices as a dialectical dialogue. *Sexual and Relationship Therapy, 22*(1), 63–75. https://doi.org/10.1080/14681990600861057

Gordon, P. (1986). Sex therapy with gay men: A review. *Sexual and Marital Therapy, 1*(2), 221–225. https://doi.org/10.1080/02674658608407730

Haldeman, D. C. (2007). The village people: Identity and development in the gay male community. In K. J. Bieschke, R. M. Perez, & K. A. DeBord (Eds.). *Handbook of counseling and psychotherapy with lesbian, gay, bisexual, and transgender clients* (2nd ed., pp. 71–89). American Psychological Association. https://doi.org/10.1037/11482-003

Hart, T. A., & Schwartz, D. R. (2010). Cognitive-behavioral erectile dysfunction treatment for gay men. *Cognitive and Behavioral Practice, 17*(1), 66–76. https://doi.org/10.1016/j.cbpra.2009.04.009

Hart, T. A., Wolitski, R. J., Purcell, D. W., Gómez, C., Halkitis, P., & Team SUMS. (2003). Sexual behavior among HIV-positive men who have sex with men: What's in a label? *Journal of Sex Research, 40*(2), 179–88. https://doi.org/10.1080/00224490309552179

Jern, P., Santtila, P., Johansson, A., Alanko, K., Salo, B., & Sandnabba, N. (2010). Is there an association between same-sex sexual experience and ejaculatory dysfunction? *Journal of Sex and Marital Therapy, 36*(4), 303–312. https://doi.org/10.1080/0092623X.2010.488102

Lacefield, K., & Negy, C. (2012). Non-erotic cognitive distractions during sexual activity in sexual minority and heterosexual young adults. *Archives of Sexual Behavior, 41*(2), 391–400. https://doi.org/10.1007/s10508-011-9792-7

Lambert, M. J. (2013). The efficacy and effectiveness of psychotherapy. In M. J. Lambert (Ed.), *Handbook of psychotherapy and behavior change* (6th ed., pp. 258–297). Wiley.

LaSala, M. (2004). Extradyadic sex and gay male couples: Comparing monogamous and non- monogamous relationships. *Families in Society: The Journal of Contemporary Human Services, 85*(3), 405–412. https://doi.org/10.1177/104438940408500319

LaSala, M. (2005). Monogamy of the heart: A qualitative study of extradyadic sex among gay male couples. *Journal of Gay and Lesbian Social Services, 17*(3), 1–24. https://doi.org/10.1300/J041v17n03_01

Macdonald, B. J. (1998). Issues in therapy with gay and lesbian couples. *Journal of Sex & Marital Therapy, 24*(3), 165–190. https://doi.org/10.1080/00926239808404931

Mao, L., Newman, C., Ridd, M., Saltman, D., Rogers, G., & Kippax, S. (2009). Self-reported sexual difficulties and their association with depression and other factors among gay men attending high HIV-caseload general practices in Australia. *Journal of Sexual Medicine, 6*(5), 1378–1385. https://doi.org/10.1111/j.1743-6109.2008.01160.x

Mark, K. (2012). The relative impact of individual sexual desire and couple desire discrepancy on satisfaction in heterosexual couples. *Sexual and Relationship Therapy, 27*(2), 133–146. https://doi.org/10.1080/14681994.2012.678825

Mark, K. P. (2014). The impact of daily sexual desire and daily sexual desire discrepancy on the quality of the sexual experience in couples. *The Canadian Journal of Human Sexuality, 23*(1), 27–33. https://doi.org/10.3138/cjhs.23.1.A2

Mark, K. P. (2015). Sexual desire discrepancy. *Current Sexual Health Reports, 7*(3), 198–202. https://doi.org/10.1007/s11930-015-0057-7

Mark, K. P., & Murray, S. H. (2012). Gender differences in desire discrepancy as a predictor of sexual and relationship satisfaction in a college sample of heterosexual romantic relationships. *Journal of Sex & Marital Therapy, 38*(2), 198–215. https://doi.org/10.1080/0092623X.2011.606877

Martell, C. R., & Prince, S. E. (2005). Treating infidelity in same-sex couples. *Journal of Clinical Psychology, 61*(11), 1429–1438. https://doi.org/10.1002/jclp.20192

Masters, W. H., & Johnson, V. E. (1966). *Human sexual response*. Little, Brown and Company.

Masters, W. H., & Johnson, V. E. (1970). *Human sexual inadequacy*. Little, Brown and Company.

Masters, W. H., & Johnson, V. E. (1979). *Homosexuality in perspective*. Little, Brown and Company.

Matthews, C. R. (2007). Affirmative lesbian, gay, and bisexual counseling with all clients. In K. J. Bieschke, R. M. Perez, & K. A. DeBord (Eds.). *Handbook of counseling and psychotherapy with lesbian, gay, bisexual, and transgender clients* (2nd ed., pp. 201–219). American Psychological Association. https://doi.org/10.1037/11482-008

McWhirter, D. P., & Mattison, A. M. (1978). The treatment of sexual dysfunction in gay male couples. *Journal of Sex & Marital Therapy, 4*(3), 213–218. https://doi.org/10.1080/00926237808403019

McWhirter, D. P., & Mattison, A. M. (1980). Treatment of sexual dysfunction in homosexual male couples. In S. R. Leiblum & L. A. Pervin (Eds.). *Principles and practice of sex therapy* (pp. 321–345). Guilford.

McWhirter, D. P., & Mattison, A. M. (1982). Psychotherapy for gay male couples. *Journal of Homosexuality, 7*(2–3), 79–91. https://doi.org/10.1300/J082v07n02_10

Meyer, I. H. (1995). Minority stress and mental health in gay men. *Journal of Health and Social Behavior, 36*(1), 38–56. https://doi.org/10.2307/2137286

Meyer-Bahlburg, H., Exner, T., Lorenz, G., Gruen, R., Gorman, J., Ehrhardt, A. (1991). Sexual risk behavior, sexual functioning, and HIV-disease progression in gay men. *Journal of Sex Research, 28*(1), 3–27. https://doi.org/10.1080/00224499109551592

Mitchell, J. W. (2013). HIV-negative and HIV-discordant gay male couples' use of HIV risk-reduction strategies: Differences by partner type and couples' HIV-status. *AIDS and Behavior, 17*(4), 1557–1569. https://doi.org/10.1007/s10461-012-0388-6

Moskowitz, D., Rieger, G., & Roloff, M. (2008). Tops, bottoms and versatiles. *Sexual and Relationship Therapy, 23*(3), 191–202. https://doi.org/10.1080/14681990802027259

Murphy, B. C. (1994). Difference and diversity: Gay and lesbian couples. *Journal of Gay & Lesbian Social Services, 1*(2), 5–31. https://doi.org/10.1300/J041v01n02_02

Nobre, P. (2013). Male sexual dysfunctions. In J. G. Hofmann (Ed.), *The Wiley handbook of cognitive behavioral therapy* (Part 2, pp. 645–672). Wiley-Blackwell. https://doi.org/10.1002/9781118528563.wbcbt28

Paff, B. A. (1985). Sexual dysfunction in gay men requesting treatment. *Journal of Sex & Marital Therapy, 11*(1), 3–18. https://doi.org/10.1080/00926238508405954

Pascoal, P. M., Shaughnessy, K., & Almeida, M. J. (2019). A thematic analysis of a sample of partnered lesbian, gay, and bisexual people's concepts of sexual satisfaction. *Psychology & Sexuality, 10*(2), 101–118. https://doi.org/10.1080/19419899.2018.1555185

Peixoto, M. M., & Nobre, P. (2014). Dysfunctional sexual beliefs: A comparative study of heterosexual men and women, gay men, and lesbian women with and without sexual problems. *Journal of Sexual Medicine, 11*(11), 2690–2700.

Peixoto, M. M., & Nobre, P. (2015). Cognitive schemas activated in sexual context: A comparative study with homosexual and heterosexual men and women, with and without sexual problems. *Cognitive Therapy and Research, 39*(3), 390–402. https://doi.org/10.1007/s10608-014-9661-5

Peixoto, M. M., & Nobre, P. (2016a). Automatic thoughts during sexual activity, distressing sexual symptoms, and sexual orientation: Findings from a web survey. *Journal of Sex & Marital Therapy, 42*(7), 616–634. https://doi.org/10.1080/0092623X.2015.1113583

Peixoto, M. M., & Nobre, P. (2016b). Personality traits, sexual problems, and sexual orientation: An empirical study. *Journal of Sex & Marital Therapy, 42*(3), 199–213. https://doi.org/10.1080/0092623X.2014.985352

Peixoto, M. M., & Nobre, P. (2017). "Macho" beliefs moderate the association between negative sexual episodes and activation of Incompetence schemas in sexual context, in gay and heterosexual men. *Journal of Sexual Medicine, 14*(4), 518–525. https://doi.org/10.1016/j.jsxm.2017.02.002

Pereira, T. J., Machado, P. P. P., & Peixoto, M. M. (2019). Sexual and relationship satisfaction: The role of perceived (non)problematic sexual desire discrepancy in gay and heterosexual men. *Journal of Sex and Marital Therapy, 45*(2), 103–113. https://doi.org/10.1080/0092623X.2018.1488323

Purcell, D. W., Campos, P. E., & Perilla, J. L. (1996). Therapy with lesbians and gay men: A cognitive behavioral perspective. *Cognitive and Behavioral Practice, 3*(2), 391–415. https://doi.org/10.1016/S1077-7229(96)80025-3

Ramirez, O. M., & Brown, J. (2010). Attachment style, rules regarding sex, and couple satisfaction: A study of gay male couples. *Australian and New Zealand Journal of Family Therapy, 31*(2), 202–213. https://doi.org/10.1375/anft.31.2.202

Reece, R. (1982). Group treatment of sexual dysfunction in gay men. *Journal of Homosexuality, 7*(2–3), 113–129. https://doi.org/10.1300/J082v07n02_13

Reece, R. (1987). Causes and treatments of sexual desire discrepancies in male couples. *Journal of Homosexuality, 14*(1–2), 157–172. https://doi.org/10.1300/J082v14n01_12

Roisman, G. I., Clausell, E., Holland, A., Fortuna, K., & Elieff, C. (2008). Adult romantic relationships as contexts of human development: A multimethod comparison of same-sex couples with opposite-sex dating, engaged, and married dyads. *Developmental Psychology, 44*(1), 91–101. https://doi.org/10.1037/0012-1649.44.1.91

Rosser, B. R., Metz, M. E., Bockting, W. O., & Buroker, T. (1997). Sexual difficulties, concerns, and satisfaction in homosexual men: An empirical study with implications for HIV prevention. *Journal of Sex and Marital Therapy, 23*(1), 61–73. https://doi.org/10.1080/00926239708404418

Rosser, B. R., Short, B. J., Thurmes, P. J., & Coleman, E. (1998). Anodyspareunia, the unacknowledged sexual dysfunction: A validation study of painful receptive anal intercourse and its psychosexual concomitants in homosexual men. *Journal of Sex and Marital Therapy, 24*(4), 281–292. https://doi.org/10.1080/00926239808403963

Rutter, P. A. (2012). Sex therapy with gay male couples using affirmative therapy. *Sexual and Relationship Therapy, 27*(1), 35–45. https://doi.org/10.1080/14681994.2011.633078

Serefoglu, E. C., & Saitz, T. R. (2012). New insights on premature ejaculation: A review of definition, classification, prevalence and treatment. *Asian journal of andrology, 14*(6), 822–829. https://doi.org/10.1038/aja.2012.108

Shernoff, M. (2005). Condomless sex: Considerations for psychotherapy with individual gay men and male couples having unsafe sex. *Journal of Gay & Lesbian Psychotherapy, 9*(3–4), 149–169. https://doi.org/10.1300/J236v09n03_09

Shernoff, M. (2006). Negotiated nonmonogamy and male couples. *Family Process, 45*(4), 407–418. https://doi.org/10.1111/j.1545-5300.2006.00179.x

Shindel, A. W., Vittinghoff, E., & Breyer, B. N. (2012). Erectile dysfunction and premature ejaculation in men who have sex with men. *Journal of Sexual Medicine, 9*(2), 576–584. https://doi.org/10.1111/j.1743-6109.2011.02585.x

Spitalnick, J. S., & McNair, L. D. (2005). Couples therapy with gay and lesbian clients: An analysis of important clinical issues. *Journal of Sex & Marital Therapy, 31*(1), 43–56. https://doi.org/10.1080/00926230590475260

Ussher, J. M. (1990a). Couples therapy with gay clients: Issues facing counsellors. *Counselling Psychology Quarterly, 3*(1), 109–116. https://doi.org/10.1080/09515079008254238

Ussher, J. M. (1990b). Cognitive behavioral couples' therapy with gay men referred for counselling in an AIDS setting: A pilot study. *AIDS Care: Psychological and Socio-medical Aspects of AIDS/HIV, 2*(1), 43–51. https://doi.org/10.1080/09540129008257712

Vansintejan, J., Janssen, J., van de Vijver, E., Vandevoorde, J., & Devroey, D. (2013). The gay men sex studies: Prevalence of sexual dysfunctions in Belgian HIV+ gay men. *HIV/AIDS - Research and Palliative Care, 5,* 89–96. https://doi.org/10.2147/HIV.S43962

Williamson, I. R. (2000). Internalized homophobia and health issues affecting lesbians and gay men. *Health Education Research, 15*(1), 97–107. https://doi.org/10.1093/her/15.1.97

Willoughby, B. J., & Vitas, J. (2012). Sexual desire discrepancy: The effect of individual differences in desired and actual sexual frequency on dating couples. *Archives of Sexual Behavior, 41*(2), 477–486. https://doi.org/10.1007/s10508-011-9766-9

Zilbergeld, B. (1999). *The new male sexuality* (Rev. ed.). Batam Books.

Zilbergeld, B., & Ellison, C. R. (1980). Desire discrepancies and arousal problems in sex therapy. In S. R. Leiblum & L. A. Pervin (Eds.). *Principles and practice of sex therapy* (11th ed., pp. 65–101). Guilford.

9

"I Could *Never* See You and Now I *Dare Not* Touch You"

Sex Therapy with Lesbian Couples

BROOKS A. BULL and JASSY CASELLA TIMBERLAKE

Lesbian couple brings to mind two people who identify as women in a sexual relationship. In this chapter, we underscore the need to identify and consistently use the client's language. For many couples which comprised two people assigned female at birth, *lesbian* would not be the descriptor of choice. Some couples may define themselves as queer, gay, or simply, a relationship which comprised two women who identify as bi- or pansexual. Two transgender women in a relationship may or may not connect with and use the term lesbian. Two people assigned female at birth may not identify as women at all but rather (for example) transgender, genderqueer, or nonbinary, and would likely see the term lesbian as inaccurate and offensive since it would not honor their gender identities accurately. It is important to find out how clients identify and then use that language. A thoughtful intake form can be helpful in this regard, and can provide the beginnings of how a couple identifies if it asks for both gender identity and relationship status.

Even though some legal strides have been made for LGBTQ people (access to legal marriage and some state-specific employment non-discrimination laws are two examples), the current presidential administration is actively attacking the rights of LGBTQ citizens nationwide by rolling back gender non-discrimination policies and fomenting racism and misogyny in both rhetoric and policies. Lesbians, as part of the greater LGBTQ community, are vulnerable to both legalistic and administrative oppressions as well as cultural stigma that results in higher rates of anxiety, depression, and suicidality in the community overall (Cochran & Mays, 2009). Black transgender women are more likely to be assaulted because of the violent cultural oppression that dehumanizes people who hold non-normative identities. Minority stress (Meyer, 2003) is the umbrella term used to describe this dynamic, a set of external stressors that exert persistent negative influence on a group for their very being. Some lesbian and queer women feel the effects of this cultural oppression more acutely than others due to the other identity positions they occupy, including and especially race, class, disability, and religious affiliation.

Pre-emptive radical inclusion (PRI; Beal, 2019) is the idea that one can and should assume that all identities are present at all times. When a client couple walks into the therapy room for the first time, a clinician using a PRI mindset would assume that the clients inhabit not just their visible identities like fat or thin, but myriad other invisible or as yet un-languaged identities like trauma survivor, transgender, working class, polyamorous, adoptee. All of the case studies in this chapter include lesbians who also hold multiple important identities like person of color, chronic pain survivor, sexual abuse survivor, etc. The work illustrated calls on all of these identity facets as the clients travel more deeply into healing sexual problems ranging from desire discrepancy, navigating sex with chronic pain, and grieving the loss of a robust sexual connection.

DOI: 10.4324/9780429274626-12

Clinical Work in a Cultural Context

Intersectionality with Lesbian Couples

The human experience of oppression exists in a matrix of intersecting influences and identity positions. Crenshaw (1989) popularized and defined the term *intersectionality* to describe this crucial concept, specifically that the experience of Black women could never be adequately understood on the basis of race or gender separately; that to deeply understand the experience of Black women, one must grapple with the layered amplification of oppression through both race *and* gender. Conducting sex therapy with lesbian couples highlights the need to consider sexuality as well as gender and race, as well as other identities related to oppression.

In the case studies discussed below, four other identity categories are especially pertinent to add to race, gender, and sexuality: class, disability status, trauma survivor status, and body size. As the case study of Edith and Hilary illustrates, a Black, working-class, fat-bodied lesbian with chronic pain has a fundamentally different and more potent experience of cultural oppression than an upper-class, physique-privileged and able-bodied white lesbian. To view these two women merely as "a lesbian couple" does not allow for their full selves to show up in the therapy room, or for transformative and socially just therapy to unfold. Additionally, trauma survivors are found at a higher rate in the LGBTQ population than the cisgender, straight population (Ellis, 2016), and consequently therapists treating lesbian couples need to be trauma-informed in their approach to couples treatment. As the second case of Vicky and Maria illustrates, attending to the trauma histories of each partner as well as the current experience of pain and oppression is crucial to the therapy process.

The American Psychological Association (APA) de-pathologized homosexuality in 1973 by removing it as a diagnosis from the Diagnostic and Statistical Manual (DSM). This gives partial explanation for why there are no peer-reviewed articles in family therapy journals about treating sexual problems in lesbian couples until the 1980s. Before the APA removed the diagnosis, all articles about queer people would have been about reparative therapy, not improving sexual function or relationships. This backdrop of oppressive pathologizing by the medical and mental health community is an unfortunate yet persistent influence with which clinicians must contend, and also accounts for the paucity of research on how to best help lesbians increase sexual satisfaction in their relationships. More specifically, literature about lesbian sexuality has mirrored limiting discourses prevalent in our culture in general about women and sexuality; for example, that women are less interested in sex than men, and that women in relationships with one another have a propensity to become enmeshed or fused (and therefore less differentiated than heterosexual couples). Both of these discourses are rooted in misogyny and homophobia, and must be challenged for therapeutic work to take hold.

Paucity of Research

Two sources are referenced throughout the body of academic literature on lesbian sexuality. Blumstein and Schwartz (1983) and Masters and Johnson (1966) set the stage for how lesbian couples came to be understood culturally and clinically. Put briefly, Blumstein and Schwartz (1983) found lesbian couples to have less frequent sex than their heterosexual or gay male counterparts. Over time, however, some authors started to critically evaluate this research. Garnets and Peplau (2001) and Iasenza (2000) critique Blumstein and Schwartz (1983) for using language in their research questionnaires that privileges a heterosexual model of sex as discrete genital acts, and argue that this language likely accounts for the inaccurate conclusion that lesbian couples have less frequent sex than their heterosexual or gay male couples. In 2006, Meana et al.

researched sexual practices of lesbians and found "that the sexual life of lesbians is more robust than often reported" and that "frequency of sexual activity and levels of sexual satisfaction were equivalent to those of heterosexual and gay couples" (p. 1). Nevertheless, "lesbian bed death" (or Inhibited Sexual Desire, as it is known diagnostically) came to be a powerful discourse in both the lesbian and larger communities. Whether it was empirically true or not, lesbians came to therapy seeking help with it. Iasenza (2000) argues that the very term "conflates two related but separate concepts—sexual infrequency and hypoactive sexual desire" (p. 61), and that a more nuanced clinical lens is needed.

Lesbian Sexual Desire: Inhibited, Discrepant, or Responsive?

Desire Discrepancy In many couples, there is one partner who wants sex more frequently than the other, creating a dynamic of high desire/low desire. Schnarch (1987) and others have described this dynamic as deeply distressing to both parties; the high desire partner often feels rejected and left alone while the low desire partner may feel sexually "defective" and therefore turn away from sexual contexts even more for fear their body "won't cooperate." As the low desire partner turns away more and more, the high desire partner may feel more frustrated and distressed, leading to—at first—a ramp up of sexual bids followed by an almost complete withdrawal from sexual initiation. Many high desire partners describe this experience with words like "I got tired of being turned down, so I stopped trying." After this dynamic plays out for a while, it is our clinical experience that a couple may present to therapy in the throes of what they might describe as "lesbian bed death," a complete lack of sex in the relationship.

Part of the therapy in these instances is to interrogate the discourse of lesbian bed death as culturally constructed and limiting. In these cases, there is often a different, more nuanced reality just under the surface—one partner expressing a desire for more sex, and another partner with untapped/unknown capacity for desire if only the painful couple dynamic could be shifted to free them from feeling broken and deficient. The therapist can open up the field of possibilities by making the distinction between total lack of sex ("bed death") and a problematic dynamic clearer:

> What you are describing doesn't sound like a total lack of desire, or a bed death of any kind; it sounds like there is actually a lot of desire for sex in this relationship, but there is something getting in the way of you accessing it. What is getting in the way?

These types of questions can be followed up with psychoeducation on the concept of responsive desire as a different way to work with desire discrepancy. We have found that this framework creates more room for client identities to be held; rather than a partner being labeled as "low desire," they can explore what in their life contributes to them accessing desire, as well as what blocks them from accessing sexual desire. Many times, what blocks clients from accessing desire has much to do with the identity positions they hold, and how those identities are being either honored or negated by both the culture at large and within their intimate relationships. The spectrum of body sizes, abilities, and races are all identity positions that can be held in such a way as to either foster or stymie the development of desire within an intimate relationship. A therapist that attends to intersectionality explores those identity positions to better understand how desire is functioning in a relationship.

Desire as a Response "Responsive desire" (Nagoski, 2015, p. 3) is a model of sexual desire in contrast to the more well-known and culturally celebrated model of sexual desire known as *spontaneous desire*. Spontaneous desire is the kind often portrayed in movies, that moment when the heroine is overcome with sexual desire, intercourse begins mere moments later, and is

followed by a gasping orgasm in two to three minutes. In contrast, responsive desire describes the experience of many women who report that their desire is dependent on context, both relational (how connected do I feel to my partner right now?) and physical (is this a sexy environment?). In fact, Nagoski (2015) reports that 30% of women *never* experience spontaneous desire, while many more women experience some mixture of both spontaneous and responsive desires.

The issue of how to frame desire—as "inhibited," discrepant between partners, or responsive versus spontaneous—is of central importance in the case study of Edith and Hilary who initially presented as a case of "lesbian bed death." Had the therapist supported this frame, the couple would likely have remained stuck and pigeonholed in the limiting discourse of disappearing female desire. However, the therapist was able to introduce the concept of responsive desire to free both partners to consider how their couple dynamic did not support eroticism in its present form. To do so, it is helpful to invite clients to read Nagoski's *Come As You Are* as well as to directly define responsive desire in a session:

> Most of us grow up thinking that sexual desire is something that just happens, like a spontaneous lightning bolt. In reality, many people—and most women—don't experience desire that way at all. Rather, many people experience what is called responsive desire—desire that is created in response to something else like your environment, or how you feel in the moment, or how connected you are to your partner. It is something you create together.
>
> *(p. 231)*

Introducing this framework moves sexual desire out of the individual realm and squarely into the couple system where it can be explored collaboratively.

Hilary and Edith: Working with Desire in Context

Hilary and Edith, a mixed-race lesbian couple of very different body sizes, came for treatment insisting that they were suffering from "lesbian bed death." The couple had been together for four years, and heightened reactivity between them, along with a distancer/pursuer dynamic, had created an increasing amount of tension and distance, which, in turn, led to less and less sex. It had been 18 months since they had been sexual with each other.

In the first session, Hilary plopped down on the couch and declaratively provided the therapist with the diagnosis: "we have lesbian bed death, and it's really become a problem for me." The therapist did not want to miss this early opportunity to broaden the working definition of the problem, and so invited Hilary to "tell me more about the bed death you are experiencing." Hilary replied, "We never have sex, and if we do it's because I have whined and complained…" Edith interjected, "I can't understand why you even want to have sex with me because you can't even stand my body!" The therapist seized on this crucial moment to identify and interrogate the oppressive discourses operating in the couple's current conceptualization of their problem beginning with the role of fat phobia and thin privilege.

> There's clearly an important story here about the role your body plays in this painful dynamic. I wonder, has the size of your body, Edith, been an issue in this relationship? And if so, how? Is that a story you're willing to tell me?

The therapist invited the clients to identify themselves in their own words and narratives, to access their direct experience and speak their fuller intersectional identities as they defined their problem. Next, the therapist added her own perspective by naming that fat phobia and "healthism" (fat phobia couched in pseudoscientific language) were present. She then provided psychoeducation about how thin privilege can be enacted in love relationships, and sometimes

without awareness. The therapist introduced this conversation with an observation followed by a question for Hilary:

> I am hearing both of you talk about the experience of fat phobia in different ways. Hilary, I hear a lot of worry and fear in your stories about how you see Edith's body. I wonder where you first learned that cultural story that big bodies aren't good bodies?

This can be a challenging moment for physique-privileged clients, and can bring up defensiveness. The therapist used their joining skills and empathic questions to connect with Hilary as a person in the system of oppression, a system that polices her body as well as Edith's.

Hilary was 30 years old—a white, cisgender female, in a socially acceptable and validated body size, and a tendency to restrict food intake when her anxiety was high. In recent months she had been experiencing high levels of joint pain (this was later diagnosed as advanced stage Lyme Disease), which was causing great distress as her work as a park ranger was primarily active and outdoors. Hilary was raised in a white, Irish Catholic family in which alcoholism was rampant. She had three siblings, all of whom were active alcoholics. Hilary was a recovering alcoholic, with four years sobriety. She was raised in a chaotic and disorganized, albeit privileged, family. Her father, a doctor whose anger and vitriol were fueled by alcohol and narcissism, held violent sway over the household. Hilary was her mother's defender, and protector to her three sisters. Hilary recalled a lifelong insistence on the part of her father that none of the women in the house should "let themselves go." Despite operating from a feminist stance of body positivity, Hilary had trouble seeing a gain in weight as anything other than laziness and a loss of desirability. Hilary said that while her friends had been excited to develop breasts in puberty, she did not share their enthusiasm. In fact, she was considering breast reduction surgery, as she was tired of hiding her body under sweatshirts and baggy sweaters. Hilary's parents paid for her college education, and she could turn to them for help whenever she felt financially challenged. Her relationship with her mother was enmeshed, and had always included a lot of physical touch—her mother would often crawl into bed with her for comfort and reassurance on the nights that Hilary's father was on a rampage. Hilary strongly associated physical touch with love and safety.

At six-foot-tall, in a non-normative body when it came to height and size, Edith was a biracial, cisgender, bisexual-identified 28-year-old woman. She had slowly started to claim the adjective "fat" to describe herself and was still struggling to accept her body, which was not easy given the years of fat-shaming bullying and torment she had endured as a child and young adult. Her father was African American and working class, and her mother was white from an upper-middle-class family, but Edith said that race and class were never talked about in the family. She and her two older brothers were raised with a strong work ethic. Her father was a car mechanic who was also in a fat body, and her mother had gone back to school to become a graphic designer when Edith was a young child, but finding money to pay rent and buy food was always a struggle, particularly after Edith's father had to retire early due to health complications from diabetes. Edith reported that there were often no meals on the table at dinnertime, and she frequently had to scavenge for food. As a child, she often felt lonely, like an afterthought in her parents' lives.

Edith was sexually abused by a female babysitter when she was six years old. Despite trying to tell her parents what had transpired, they did not believe her and the sitter continued to take care of Edith until she was in her early teens. Edith loved her work with trauma survivors at a local domestic violence shelter, but struggled with money as a result of her low salary, often falling behind on her share of the rent and expenses, and occasionally not having money to put gas in her car. Edith's sexual history included online sex with men in her adolescence, including with a man eight years her senior, who had made her feel protected and encouraged her to see herself as beautiful.

Couple Dynamics

Hilary had racial, body, and economic privilege that she wielded with little awareness of the impact it had on Edith. Edith was raised with silence around race and class, and gaslighting around sexual abuse and bodily autonomy. She had not yet found her voice and felt silenced in her relationship with Hilary. Hilary earned significantly more money than Edith, worked fewer hours, and had more time to devote to self-care, such as exercising, sleeping well, and making intentional food choices. She was highly critical of Edith's struggles with money. Edith's response was to feel silenced by Hilary's criticisms, and to pull away from her.

Edith said that she found Hilary's frequent angry outbursts and harsh criticisms of her body size very challenging, and she did not understand how Hilary could in one moment say she wanted to have sex, and in the next moment issue an ultimatum that Edith should lose weight and equate this with Edith taking care of herself. Hilary regretted telling Edith that although she liked having sex with her, she did not like her body, singling out Edith's large belly and thighs. She regularly policed Edith's food intake, commenting on her food choices and making frequent negative observations about her body, couched in an "I'm only being honest!" frame that made it increasingly difficult for Edith to want to be sexual, or even physically intimate, with Hilary. Simply put, Hilary experienced a high desire for sex, but was in a relationship with somebody she loved but was not attracted to. Edith was also high desire for sex, but low desire for sex with Hilary, because of Hilary's negative feelings about Edith's body. In session they were both clear that they would like to be sexual at least twice a week, so this was not a case of discrepant desire. Rather, the problem was rooted in a dynamic that stymied their ability to connect.

Hilary's urgency about having sex often enough was read by Edith as pressure to be sexual when she was not ready, and this consistently activated her trauma response. Edith reported that she would frequently have sex with Hilary in response to the pressure, and would feel dissociated.

Despite Hilary's perception that Edith was "sexually cold," Edith actually had desire for arousal and sex, and masturbated regularly. Her trauma history, coupled with the body shaming she experienced with Hilary, made accessing her desire difficult. "It's not that I don't want to be sexual, I masturbate about three times a week! I like sex! I want to have sex with someone who likes my body, and you don't," Edith cried out in a session about three months into treatment. Edith's sadness at the loss of sex in her relationship with Hilary was palpable—she said that Hilary was the first woman she had ever had sex with and had found it electrifying. The therapist responded,

> you both really want more sex, I hear that clearly! Although it initially felt like there was no desire in this relationship, the project for you two is really to understand how desire works for one another. Edith, your desire is really responsive. When you feel criticized for the size of your body, or if Hilary comments on wanting you to 'take care of yourself better' while you are eating, it hurts, and it gets in the way of you wanting sex with her. Is that right? Hilary, that's the fat phobia we have talked about—all of those messages you inherited from your parents about health and size, right? That is some powerful and oppressive stuff you came with, and I see how badly you want to put that down and connect with Edith. And, to make things even more layered, Hilary, your desire is not as sensitive to outside forces. You can and want to have sex with Edith even when you two are really at odds, right? It can feel like a way to reconnect, yes?

By framing the problem as a project of discovery, and of attuning to Edith's need to be accepted and loved just exactly as she is, the therapist was able to shift the problem from "Edith's low desire" to a dynamic in which Hilary had a lot of ability (and responsibility) to shift.

Interventions Used

Sexual History Assessment as an Intervention Each partner completed a comprehensive sexual history form, which was helpful in illuminating differences in each partner's experience of sex. A thorough sexual history assessment includes how and where the client learned about sex, what experiences they have had alone and with partners, their experience of fantasy and masturbation, any pain or discomfort they feel in regard to sex, and a thorough examination of the meanings they hold about sex, sexuality, and pleasure. Gathering this information deeply informs treatment as the details of how each partner experiences sexuality are unique. For example, Edith stated that her sexual fantasies always involved people desiring her passionately and being highly demonstrative of the ways in which they desired her. Hilary, however, had visceral fantasies that lacked words or images, and she struggled to put feelings to her wants and desires. This made it challenging for her to communicate desire for her partner in the way that was meaningful to Edith. This type of information would have been hard to glean had it not been for the thorough and structured sexual history gathering process at the outset of treatment.

Stabilization via Gottman In order to stem the level of hostility and contempt between the couple, Gottman Method couple therapy (Gottman, 1990) interventions were used to improve communication dynamics. This diminished the amount of criticism, defensiveness, and contempt they expressed and allowed for less reactive communication. Using heart rate monitors during sessions helped the couple to increase the number of successful conversations about sex and improved their understanding of their different erotic templates. They learned how to repair ruptures in their relationship faster, with less emphasis on who's right and more emphasis on power sharing in the relationship. With less rupture, and more stable communication, Edith became less avoidant and more interested in spending time with Hilary. With a decrease in tension between the couple, Edith was able to tolerate an increase in connection and initiated more affectionate and playful touch with Hilary, who was relieved by the affectionate cuddling and touch, and subsequently became less anxious about sexual frequency. With less reactivity, the couple was also able to have more nuanced conversations about their positionalities vis-à-vis class, race, and body size and came to understand how unexplored these different—but intersecting—identities had prevented full understanding of what was driving their disconnect.

Body Maps One of Hilary's chief complaints was that Edith constantly rejected her touch. Edith said that Hilary's touch was "grabby" and that her attempts to initiate sex focused on tickling and clutching at Edith's belly, grabbing handfuls of her body fat. Edith experienced this touch as triggering and emotionally distancing, particularly as Hilary's criticisms of her body centered around Edith's stomach and "love handles." Hilary would complain that she couldn't touch Edith "anywhere on her body." This came out in session when Hilary said, "I can't touch her anywhere! There's no 'in' for me!" To which Edith responded, "I've told you that I like stroking and snuggling. Gentle touch is what I like! The tickling and belly grabbing feel alienating and distracting." After validating each partner's experience, the therapist redirected the partners to the project of "better understanding one another" that was first initiated in conversations about desire.

> So, help me understand, how does sex get initiated? Who starts it and how? I'm wondering because touch is clearly so important to you both, and Hilary it sounds like you don't feel like you know how to touch Edith in ways she likes at this point. Would it be helpful to have more of a roadmap that would help you understand how to initiate touch with Edith in a way that she can respond to positively?

In order to facilitate this increased understanding about their different arousal styles and preferred pathways to sexual intimacy, the couple completed body maps (Zoldbrod, 1998). For this intervention, each partner is given four simple drawings of a blank human figure—two showing the front of the body, and two showing the back of the body. Clients are asked to color in those figures in three colors: green for areas that are always OK to touch, yellow for areas that are sometimes OK to touch, and red for areas that are never OK to touch. The first pair of drawings is their map of touch in a pre-arousal state, and the second is their map of touch when they are aroused. These indicated in easily legible form how and where on their bodies they each liked to be touched, both pre-arousal and during arousal. In sessions, the maps were used as a road map for them to learn how to touch each other in ways they each found pleasurable. Hilary was greatly relieved to see that Edith was not averse to touch; she just needed Hilary to touch her in ways that didn't trigger an aversive trauma response and allowed for a conduit to arousal. In addition to the need for Hilary to make repairs for the body shaming criticisms she has leveled against Edith, the idea of developing a way to engage sexually with Edith using "safe touch" (Maltz, 2012) was explored. The therapist discovered that Hilary had a lifetime of not wanting to feel aroused, as she equated it with possible rejection. Eventually, with encouragement, she was able to allow herself the feelings of arousal and claim them as her own enjoyment of her body, separate from her fear of partner loss.

Sensate Focus After each partner had a better idea about how and where the other liked to be touched, a newly conceptualized version of sensate focus touch was used in order to enact the new learning they had gained from body mapping. Sensate focus exercises invite partners to get acquainted with their own bodies, how they receive touch as well as provide partners with practice in giving mindful touch to their partner. Often, people know how they don't want to be touched, but struggle to find the language for what they do want. In the act of slowing down using the structure of a sensate focus exercise, partners are given permission to explore how touch feels, and communicate their touch preferences as they arise. The couple was instructed to maintain eye contact while taking turns slowly receiving touch from their partner. If they became anxious while receiving touch—or in Edith's case started to dissociate—they were asked to halt the touch by holding the partner's hand and do self-soothing breathing exercises, learning how to co-regulate the anxiety between them, before returning to touch once more. Edith reported that this work allowed her to feel that she was gradually "crawling back" into her body again. It also demonstrated to Hilary that sexual touch was possible for Edith if consensual and safe touch was used in their sexual interactions.

Differentiation Work Over time, the couple came to understand that their differing anxieties were preventing them from engaging with each other in close and meaningful ways. Using concepts of differentiation from Schnarch's (1987) Sexual Crucible model, the couple learned to manage anxiety not by *ignoring* it but learning how to contain their reactivity using self-soothing, while reaching for a more profound and intimate connection. The "Hugging Till Relaxed" exercise (Schnarch, 1997) was prescribed to help the couple understand their dynamic, and provided a window into the partners' relationship in real time. Hilary realized that she would use hugging as a way to manage her anxiety, using Edith's body as a way to stabilize her. Edith said she discovered that she used the exercise as a way to soothe Hilary so that her own anxiety could be lessened. Understanding the enmeshed dynamic that this illuminated helped the couple to learn how to "stand on their own two feet."

The concept of sexual styles (Mosher, 1980) was also used to identify how the couple engaged with each other sexually. Edith identified her sexual style as a Trancer (someone who tends to be more internal during sex, prefers rhythmic and repetitive touch, and feels disrupted by talking or unexpected eye contact during sex), and Hilary as a Partner Engager (someone who feels more arousal and pleasure if they are in communication verbally and nonverbally with their partner during sex and who values above all the feeling of connection to their partner as a marker of fulfilling sex). Understanding their different styles allowed the couple to engage sexually in ways that built a bridge between their two styles and to find a way toward sexual engagement that worked for both of them.

Maria and Vicky: Working with Pain and Loss

Vicky and Maria, both aged 50, showed up in the therapy office at their wits' end. They had been a couple for ten years, and started by explaining "we really love each other, we communicate really well, and we used to have a great sexual relationship but now Vicky has LS and sex is completely off the table. We're both sad and suffering." Vicky was a cisgender, white, working-class, visually disabled woman who was experiencing significant challenges with vulvar pain as a result of a debilitating case of Lichen Sclerosis (LS), a chronic inflammatory disease which can result in clitoral scarring and labial fusion. These challenges were both emotional and sexual. Her primary care physician had been minimally helpful in treating Vicky's symptoms. Vicky was legally blind, used a white cane to navigate her way through the world independently, and worked as a social worker with families with special needs children. At the time of their first appointment, her job was at risk as she had exceeded her allowed number of sick days due to multiple visits to her doctor and hospital appointments since the onset of LS. Vicky was raised in a close, working-class, Irish Catholic Boston family, the first in her family to attend University and to have a white-collar job. Her father had worked in a department store warehouse until his retirement, and her mother was a hair stylist who had owned her own small salon in the East Boston neighborhood where Vicky was raised. Vicky had previously been married to a man, and her parents still had difficulty accepting Vicky's sexual orientation but tried their best to be supportive.

Maria was a Latinx woman of Puerto Rican descent. When Maria was a small child, her parents moved to the Boston area from Puerto Rico, where they both had been professors at the University of Puerto Rico. They had since retired from academic life and lived on the first floor of the house she shared with Vicky. Part of a large, extended, Catholic family, Maria had also experienced some push back when she first told her parents that she was a lesbian, but they had grown to love and accept Vicky as a member of the family. Maria was a professor in Social Work studies at a local community college. She had come out as a lesbian in her late teens and had never had sexual relationships with men. Maria believed Vicky to be the love of her life and was struggling with the erosion of both their sexual *and* physical connections, as this had previously been a substantial and important part of their relationship.

LS caused significant disfigurement of Vicky's vulva and clitoris, including clitoral scarring and partial labial fusion, and had dramatically impacted Vicky's quality of life and devastated her sexual self-concept. Prior to developing LS three years into their relationship, Vicky said that she had been the partner who had higher desire for sex, but this had changed dramatically after LS. Becoming sexually aroused inevitably led to increased blood flow and this engorgement caused discomfort due to the cracking of vulvar scar tissue, resulting in painful labial fissures. This pain understandably led to sexual avoidance. Before the LS symptoms became so problematic, the couple had negotiated their discrepant desire well—Maria knew how much Vicky loved and desired her. She could tell that Vicky delighted in touching her body and knew that Vicky's

enjoyment of sex focused on touch, scent, and sound as visual images were not available to her. Vicky expressed comfort at having been the higher desire partner, and said that she understood her higher desire for touch as being rooted in the importance for her that physicality played in maintaining connection with Maria.

The couple had been in couple therapy prior to attending sex therapy and had good communication skills. They typically handled conflict well, were able to consistently listen to each other respectfully, and easily accepted each other's influence. Conflict in the relationship was handled promptly, and there was a high level of differentiation in the relationship, leading to low levels of reactivity. They had learned to have complicated conversations about money, and how they each viewed the importance of money, and were on the same page when it came to how they spent and saved. They were also able to relate their different ways of handling money to their class differences. Vicky's discomfort about the possible loss of earnings, due to her medical absences, was related to how much she might have to rely on Vicky for financial support. She had been raised to value the importance of work and independence, and understood that her family had limited financial resources. Maria was raised in a family with more disposable income, with little focus on independence, but with an understanding that her family would always be there to support her financially if the need arose. The couple was able to discuss these differences easily, and make decisions readily.

Issues of difference and privilege arising from the couple's interracial relationship had also surfaced early in their history together. Vicky learned to speak Spanish so that she could better communicate with Maria's extended family, some of whom did not speak English. She learned about Maria's culture, and over time because more aware and increasingly attuned to the ways in which issues of race surfaced in their relationship, and more able to confront ways in which her own white privilege emerged in the context of their relationship.

However, the loss of the couple's ability to be sexual created a crisis in their relationship, one that they struggled to handle together despite a previous ability to negotiate conflict adeptly. As the high desire partner, Vicky had also been the one who was more likely to initiate being sexual. This shift in their relationship dynamic created challenges for both women, and Maria explained in the first appointment that she felt sad at the distance in the relationship since both sex and affectionate touch had diminished in frequency. Early in treatment, Maria said, "It's so frustrating that I can see her and can't touch her." Vicky responded, "I could *never* see you and now I *dare not* touch you." As is the case with so many couples who are struggling with the presence of sexual pain in their relationship, navigating the feelings of loss and sorrow is foundational to clinical work.

Interventions Used

Referral to Medical Providers The first step in treatment involved making a referral to a local gynecologist who had a practice specializing in sexual medicine and sexual pain disorders. The doctor confirmed the diagnosis of LS, and after steroid ointment proved minimally helpful, a course of steroid injections was also prescribed. Vicky reported that this dramatically decreased the itching associated with LS and within a few weeks she had decreased symptomology. She was disheartened to learn that there is no cure for LS—merely management of symptoms, plus an ongoing annual regimen of medical visits due to the risk of the development of squamous cell carcinoma in LS sufferers. While the steroid treatments helped with itching and the structural integrity of the thinning skin, they did not significantly minimize vulvar pain; therefore, the doctor also diagnosed a low-dose course of Tricyclic antidepressants in order to decrease the pain that resulted from lesions.

Touch Continuum When sexual touch becomes problematic in an intimate relationship, there is a tendency for partners to shrink away from other forms of touch that are sexually adjacent, and so eventually sensual touch and even healing and affectionate touch become more threatening. Finding ways to include more forms of touch while giving permission in this instance for sexual touch not to be present was crucial. Vicky's tendency had been to shy away from sexual touch due to the painful ramifications from the ensuing arousal, but unfortunately this led to the erosion of other forms of touch. Using the touch continuum (Britton & Hodgson, 2003), treatment focused on increasing other forms of touch available to the couple, including healing, affectionate, and sensual touch. Vicky's enjoyment of sex had primarily focused on touch, scent, and sound. Because LS had made sexual arousal extremely painful, treatment focused on enhancing connection through sensual and affectionate channels of sensory input and to find ways to pay attention to each other's bodies that did not include sexual play.

The therapist introduced this by first explaining and giving concrete examples of each type of touch.

> Touch exists on a continuum. One on end there is casual, incidental touch between partners, like when you graze Vicki's hand when reaching for the salt at the dinner table. Next comes affectionate touch—that's when you touch Maria on purpose and maybe give a little stroke or pat on her shoulder or back to communicate your love. Therapeutic touch comes next. Massages, or other forms of healing touch fall into this category. Sensual touch is the next category, and that encompasses all the kinds of touch that feel good and pleasurable but are not in the sexual or erotic category (but they might be close!). This could include a massage that goes beyond "working out a knot" to a more sensual or intimate touch, a massage that lovers would give one another. Lastly, we have sexual touch—touch that arouses and stimulates, and perhaps leads to orgasm but certainly not always. Oral sex, fingering, and penetration would fall into this category. Vicky, this is the kind of touch that has been so painful for you since developing LS. Can we talk about how you experience all the other kinds of touch on the continuum?

It is the personal meaning ascribed to touch that determines which category it is in for a client. For some people, kissing can migrate from affectionate to sensual to sexual. For others, it always resides in the sexual category. This was an important conversation for Maria and Vicky. When they realized that Vicky was avoiding almost all touch because she was very fearful of the possible migration from affectionate touch (which felt great to her) to sensual touch (which sometimes felt OK and sometimes did not), they could then make more deliberate choices and agreements about how to touch and how to communicate in the moment if it needed to stop in order to avoid pain for Vicky. Introducing the touch continuum should elicit exploration from the clients, not rigid categorization from the therapist about what particular types of touch mean.

Grief Work After partially stabilizing Vicky's physical symptoms, much of the clinical work with Vicky and Maria involved helping them navigate feelings of frustration, grief, and loss. The grief work in treatment focused on two different types of grief and loss: acute and abiding. This involved the therapist tracking the micro-moments of interaction between the partners and mined those exchanges for opportunities to help the couple join one another in their shared grief. Maria would often say "I'm going to touch your face now, sweetie" when Vicky appeared to be sad or tearful. Since Vicky was blind, Maria wanted to warn her when she was about to touch her so as not to take her by surprise. She would gently hold her hand to Vicky's face, and

the two would have a moment of nonverbal connection. When the therapist saw this exchange, she slowed the couple down and said, "Maria, you asked permission to touch Vicky's face just now. It's beautiful how you bring consent into your interactions with so much love. Vicky, how does it feel when Maria asks for your permission to touch you so gently?" Vicky responded, "it feels like she is really with me in this." With the couple in a deeply connected emotional state, the therapist gently reflected:

> This is so sad, and you both are experiencing a lot of grief. [Pause in which both clients nodded their heads]. Can we make space to talk about how it used to be? Can you tell me what it was like in the early days of knowing one another? What was your experience of being sexual then?

Inviting Maria and Vicky to talk about the passionate, robust sex life they used to have—although deeply sad for both of them—was crucial to their process of reconnecting and moving forward anew.

While the therapist continued to help them express sadness and be witnessed by each other in that sorrow, she also reminded them that it is also okay not to grieve all the time. They were encouraged to focus on having fun together, building their connection and love maps through other channels while developing patience for the difference in each other's process—in any type of emotional process, partners don't always reach the same point at the same time.

Conclusion: Universal Clinical Guidelines

Assessment

Because we value the complexities of each client's identity and experience, we believe that it is paramount to do a thorough genogram with each client. Genogram conversations can elicit not simply demographic information like birth order and how many siblings each partner has, but also how each partner's family identifies culturally and racially, what socio-economic status they grew up in, and all instances of abuse and infidelity throughout the generations. In this way, a focus on intersecting identities is present from the very start of treatment. The therapist demonstrates through the thorough gathering of individual identity information that it matters who each partner is, where they come from, and how they understand themselves in relation to one another. It is also useful to gather information about how each family expressed emotion when the partner was a child, which emotions were welcomed and which were not, how people dealt with conflict, and how each partner understands these patterns as part of their family and racial culture.

Another important assessment process is the sexual history questionnaire, a semi-structured clinical interview that asks each client to trace the history of how they first learned about sex and sexuality, what messages they received in their family and in the larger culture, and what experiences they have had and with whom. This process can take multiple sessions, and deeply informs how treatment proceeds.

Psychoeducation

Offering clients access to accurate information about their bodies and sexuality can be profoundly normalizing and liberating. For instance, when Vicky learned the truth that there was no way to return to her previous experience of sexual functioning due to her severe LS, she shifted from seeing herself as fundamentally broken to working with her partner to grapple with the loss of their previous sexual relationship. Although deeply sad and painful, the impact

of understanding the nature of her condition was immediate and deeply therapeutic. No longer did she position *herself* as the problem, and the couple moved from a system that supported the view that Vicky was the identified patient to a collaborative system of two partners looking for creative solutions for how to connect in other ways as they lived alongside LS. We advise direct psychoeducation during sessions as well as pointing clients to resources like books and podcasts that accurately address their issues.

Referrals to Medical Providers

Sex therapy is often done in conjunction with medical treatment especially when physical pain is part of the presenting problem. It is crucial for therapists to refer clients to medical doctors to rule out serious medical issues that could be a factor. Seeking out relationships with LGBTQ-affirmative medical providers, including pelvic floor physical therapists, is recommended.

Therapist Position

We advise a therapist posture of knowledgeable, nonjudgmental leadership for this type of work. It is important to offer clients accurate, scientifically based information about their sexual issues, and to correct misapprehensions if they are present, particularly if clients are operating under false and shaming information about their bodies or sexuality. That said, deeply honoring each client's expertise about their own experience is the way to create the necessary safety for therapeutic work to take hold. Being upfront and vocal about different identity positions and how those differences operate in the therapy room is required both between the partners and among the client couple and therapist.

References

Beal, C. (2019, October 1). *Preemptive radical inclusion.* https://justiceandpeaceconsulting.com/preemptive-radical-inclusion/

Blumstein, P., & Schwartz, P. (1983). *American couples: Money, work, and sex.* Morrow.

Britton, P., & Hodgson, H. (2003). *Idiot's guide to sensual massage.* Penguin.

Cochran, S., & Mays, V. (2009). Burden of psychiatric morbidity among lesbian, gay, and bisexual individuals in the California quality of life survey. *Journal of Abnormal Psychology, 118*(3), 647–658. https://doi.org/10.1037/a0016501

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum, 1*(8), 139–167. https://chicagounbound.uchicago.edu/uclf/vol1989/iss1/8

Ellis, A. E. (2016). *Trauma and posttraumatic stress disorder in lesbian, gay, bisexual, transgendered, and queer individuals.* https://www.apatraumadivisian.org/633/resource-on-underserved-populations.html

Garnets, L. D., & Peplau, L. A. (2001). A new paradigm for women's sexual orientation: Implications for therapy. *Women & Therapy, 24*(1–2), 111–121. https://doi.org/10.1300/J015v24n01_14

Gottman, J. M. (1990). *The marriage clinic: A scientifically based marital therapy.* Norton.

Iasenza, S. (2000). Lesbian sexuality post-stonewall to post-modernism: Putting the "lesbian bed death" concept to bed. *Journal of Sex Education and Therapy, 25*(1), 59–69. https://doi.org/10.1080/01614576.2000.11074330

Maltz, W. (2012). *The sexual healing journey: A guide for survivors of sexual abuse* (3rd ed.). Harper Collins.

Masters, W. H., & Johnson, V. E. (1966). *Human sexual response.* Bantam.

Meana, M., Rakipi, R. S., Weeks, G., & Lykins, A. (2006). Sexual functioning in a non-clinical sample of partnered lesbians. *Journal of Couple & Relationship Therapy, 5*(2), 1–22. https://doi.org/10.1300/J398v05n02_01

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129*(5), 674–697. https://doi.org/10.1037/0033-2909.129.5.674

Mosher, D. L. (1980). Three psychological dimensions of depth of involvement in human sexual response. *Journal of Sex Research, 16*(1), 1–42. https://doi.org/10.1080/00224498009551060

Nagoski, E. (2015). *Come as you are*. Simon & Shuster.

Schnarch, D. (1987). *Constructing the sexual crucible: An integration of sexual and marital therapy.* Norton.

Schnarch, D. (1997). *Passionate marriage: Love, sex, and intimacy in emotionally committed relationships.* Norton.

Zoldbrod, A. (1998). *Sexsmart: How your childhood shaped your sexual life and what to do about it.* New Harbinger Publications.

10

Sexuality and Desire Landscapes in Transgender, Nonbinary, and Genderqueer Relationships

ARLENE I. LEV[1] and SHANNON L. SENNOTT

Introduction

The lack of attention to the erotic lives of transgender, nonbinary, and genderqueer (TGNBQ) people is hardly surprising, given the hostile scrutiny of the public gaze specifically directed toward those who transgress the social norms of gender identity and expression as well as the long tradition within the psycho-medical communities of pathologizing sexual minorities. In fairness, there is an overwhelming silence regarding all serious inquiries in the sphere of general human sexuality. Despite the commercial exploitation of sex in advertising, the popular media where sexism is ubiquitous, and the widespread availability of internet pornography, sexuality and eroticism remain inadequately explored topics. From societal fears of teaching sex education in public schools to the inadequate funding of sex research in higher education, authentic discussions of human sexuality are rare and mostly guided by a "don't ask, don't tell" philosophy. This is especially noteworthy in the social sciences, where sexuality remains a taboo topic within psychology, social work, and marriage and family therapy training (Pope et al., 2006). Sexuality-specific clinical research and therapeutic skills-training focuses explicitly on the needs of LGBTQ people, remains limited to same-sex-identified sexuality (i.e. lesbian and gay people), and completely ignores other sexual and gender minorities.

TGNBQ eroticism is unexamined and poorly documented within the scholarly literature (Lev, 2014), leaving people erotically marginalized. The term *erotically marginalized* describes those who are at risk of being pathologized and oppressed both inside and outside the clinical setting due to their sexual and gender identities, orientations, and practices, and is inclusive of not only transgender experiences but also the sexual and identity landscapes of nonbinary (NB) and genderqueer people (Constantinides et al., 2019).

The media sensationalizes gender-affirming treatments and medical interventions, focusing on surgical operations and physical transformations. Paradoxically, TGNBQ people are eroticized and exoticized—except of course when they are viewed as non-sexual and incapable of human intimacy. In truth, TGNBQ identities have been so infrequently studied that much of what is "known" is based on inference and conjecture. TGNBQ bodies and sexualities cross the traditionally established sex binary and their sexual relationships frequently (though not

[1] We, Arlene Lev and Shannon Sennott, were asked to coauthor this chapter for the first edition of the book in 2010. When we were asked to rewrite this chapter for the second edition, we were both aware of the importance of locating our social position. We both have years of clinical experience working with LGBTQ people. We have written this chapter with careful attention to our power and privilege as cisgender women, who also have white privilege. We also recognize that we are speaking about the sexual lives and erotic landscapes of trans and nonbinary people, and even our own intimacy with these communities does not lessen our own status as outsiders. We have devoted our work as therapists to understanding and naming our privileges in order to create the most transparent therapeutic environment possible for our clients. It is from this social and professional location that we both hold the writing of this chapter.

DOI: 10.4324/9780429274626-13

definitively) defy traditional expectations. Gender congruence and secure embodiment are often achieved following emotional introspection and expensive and invasive medical treatments. Sexuality, intimacy, and passion are often negotiated through shifting perspectives of sexual orientation and desire; erotic pleasures may be revealed that defy heteronormative expectations. Sometimes, desire and/or sexual orientation does not manifest clearly until gender identity has been solidly attained; it can sometimes be hard to actually know who one is sexually attracted to, if one is not able to accurately identify their own gender to themselves.

Terminology and Language that Supports TGNBQ Clients

Terminology about sexuality continues to evolve and shift as diverse sexual and gender communities continue to nuance their identities and self-descriptions. Nichols (2000) says, "There are problems inherent even in arriving at common definitions of sexual minorities, because the phenomena we are attempting to define are so variable and complex" (p. 337). In this chapter, we use the acronym TGNBQ to refer to TGNBQ people. Often, TGNBQ people are conflated within the larger LGBTQ nomenclature. By separating out the T and Q from LGB, and adding NB, we are acknowledging multiple intersecting and overlapping communities of erotically marginalized people for whom gender identity and expression are a significant and prominent part of their self-identity. The term *cisgender* is used to describe people who identify with the gender that they were assigned at birth (Richards & Barker, 2013). In Latin, the prefix *cis* means "on the same side" and *trans* means "on the opposite side;" cisgender people identify with the same side (of the binary) which they were assigned at birth, and those who are trans move to (or toward) the other side. We name both trans and cis identities, which challenges the dominant practice of only naming identities that occupy marginalized positions; naming both transgender and cisgender identities illuminates the experience of gender embodiment for everyone (and yet can also create another binary!).

Transgender can be used as an umbrella term to include all gender-nonconforming people, including many who may not want to be subsumed under this umbrella (Lev, 2004). Some people who identify as transsexual—often those who live full-time as (binary) men or women and have transitioned[2] medically, surgically, and legally—do not identify with the larger transgender movement; they identify simply as men or women. There is sometimes hostility from transsexuals toward those with more fluid NB identities; the celebration within transgender communities toward those with unique gender expressions is seen as minimizing the deep emotional pain and medical need of transsexuals. There is also hostility from the larger LGB community toward transsexuals, who are accused of reifying the binary, and endorsing outdated binary sexist viewpoints of men and women (Roen, 2002). Intersex people, who may or may also not identify as transgender, are sometimes included in this larger trans umbrella. Intersex is a broad term to identify people whose bodies do not simply fit Westernized binary definitions of female and male. An estimated 1.7% of humans are intersex, about the same number of people who have red hair (Viloria & Nieto, 2020). People who identify as transsexual and intersex often have complex bodies and may have similar concerns as other erotically marginalized people.

The term *nonbinary* identifies genders that are outside of the female-male (or woman-man) binary, and can encompass complex and varied understandings of human gender identities (Richards et al., 2016). *Enby* (as in N.B.) is a phonetic term for NB and is a self-identification that some NB people use. It is common for people who identify as NB to use inclusive

[2] The term transition is a complicated word to use, as it assumes that people are in a process of changing from one state to another, and possibly also signaling an end-point (i.e. post-transition). We use the term in a more general way to highlight the changes that TGNBQ people may experience as their identities, bodies, and relationships shift.

pronouns, such as they/them/theirs, xe/xem/xyers, or ze/hir/hirs (Constantinides et al., 2019). Using correct pronouns consistently is essential when working with all TGNBQ people, and using gender-neutral pronouns when working with NB people is imperative, so they feel seen and respected; this is especially true in sexual contexts (Constantinides et al., 2019). When an NB person is engaging in sexual practices, they may want partners to use language and names that are specific to only their body. Sex therapists working with partnerships that include individuals identifying as NB can model asking what descriptive language a client may use for sexual practices and body parts.

Genderqueer describes people who express or play with their gender in a way that blurs or blends the boundaries of typical binary constructions. Being genderqueer is not always mutually exclusive of other gender identities. There may be an overlap of sexual orientations and a gender presentation that defies normative and conforming expectations of gender. This means that a person might identify as both genderqueer and trans, or genderqueer and femme, or only genderqueer. An overlap of pansexuality and genderqueerness might appear in many different ways and people who identify as both may be perceived in mainstream culture as binary in their presentation. For instance, a woman who is both bisexual and a female-affirmed trans person, who is partnered with a bisexual trans-male partner, may be perceived to be a heterosexual couple when walking down the street, although this is not their life experience or their identity. It is for this reason that a therapist ought to not make any assumptions about a client's erotically marginalized identity constellation upon first meeting them (Constantinides et al., 2019; Richards et al., 2016). TGNBQ identity constellations also intersect with lesbian, gay, bisexual, asexual, demisexual, and pansexual sexual orientations. Most readers are likely familiar with lesbian, gay, and bisexual identities; *asexual*, often phonetically referred to as "ace," describes a lack of desire or sexual attraction, or a decreased need to act on sexual feelings. *Demisexual* indicates that a person's sexual attraction to others is not strongly present, or the attraction may be contingent on other relationship factors, including a feeling of closeness and deep friendship before an attraction can develop. The Latin prefix "pan" means "all," and someone who is *pansexual* is attracted to and open to sexual relationships with people of any and all genders. The term pansexual is similar to bisexual, although the term is thought by some to be more inclusive of people who have trans/NB identities.

Societal Oppression of TGNBQ Clients

The reality of discrimination, bias, and physical violence in the daily lives of TGNBQ people has been well documented (Alessi, 2014), as has the negative impact this abuse has on their psychological stability (Lombardi et al., 2001; Nuttbrock et al., 2010). Assaults on identity are additionally influenced by "intersecting social positions, such as ethnicity, social class, citizenship status and passability" (Schuylenbergh et al., 2018, p. 135). One national transgender survey (James et al., 2016) revealed nearly 40% of respondents experienced serious psychological distress in the past month, and 40% have attempted suicide during their lives. Twenty-three percent did not seek health care due to fear of being mistreated; another 33% did not seek health care due to finances. Nineteen percent of Black transgender women were living with HIV, and transgender people with disabilities were more likely to experience serious psychological distress (59%) and suicidality (54%); 42% reported mistreatment by health care providers. Additionally, workplace discrimination is ubiquitous; in one study, nearly 50% of TGNBQ people experienced an adverse job-related action, and 97% experienced mistreatment or harassment at work (National Center for Transgender Equality & National Gay and Lesbian Task Force, 2009).

It is difficult to imagine that such daily stressors as these do not impact the sexual desires, behaviors, and experiences of trans people, as well as increase risky sexual behavior, including

inconsistent safer sex practices, and an increase of negative coping strategies like recreational drug use. Emerging research also shows high levels of sexual violence (Callander et al., 2019; Fernández-Rouco et al., 2017; James et al., 2016; Wirtz et al., 2018). Additionally, trans people are vulnerable to domestic violence and sexual assault within their most intimate relationships (James et al., 2016). As Devor and Dominic (2015) have said:

> When sex characteristics and gender presentations are known to not align in typical ways—which is much more likely to become known in sexual situations—trans people become much more vulnerable to a number of indignities and dangers. They may be objectified or fetishized, have their gender identities invalidated, be denied due respect, or be abused, violated, assaulted, or murdered.
>
> *(p. 189)*

Sometimes, it is not the transition itself that is challenging for trans people, but rather discrimination and societal stigma that impacts how they are seen and treated by even their most significant intimate partners.

Taking a Sexual History of the History of TGNBQ Sexuality

There has been little substantive research on human sexual behavior, and trans and queer sexual practices have even more rarely been the focus of empirical studies. Prodigious attempts to gather research data for this chapter provided few results, much of which focused on surgical success, or data collection on HIV and STI prevalence—although in the past decade, there is an increase in the number of scholarly articles. Pairing the words *transgender, trans,* or *transsexual* with *sex, sexual*, or *erotic* in extensive academic interlibrary searches repeatedly yielded "zero results" or, occasionally, a general article on "LGBT social services," even when the topic had nothing to do with "T" people. The same words entered into internet search engines revealed a colorful pornographic array of human sexual expression and camcorder invitations, displayed in overlapping pop-up windows downloading furiously to a home-based computer, initiating a sudden paralyzing fear of the potential consequences that could befall a scholar of sexuality living in a post-Patriot Act Trump America. A few web-based articles discussed safer sex practices, and cisgender bloggers shared personal experiences having sex with trans-identified people; trans bloggers shared their personal sexual experiences far less frequently. The voice of trans people speaking about their own sexuality, desires, and experiences is a newly evolving public voice, one that will surely transform this discourse in the coming decades.

Contemporary understandings of human sexuality are rooted in eighteenth- and nineteenth-century sexology when the relationship between what we now call same-sex sexuality and gender diversity was not clearly delineated. It was unthinkable to medical scientists of that era that sexed bodies could exist outside of a male-female binary, or that healthy sexual pleasure could exist outside of heteronormative boundaries (Hekma, 1994). Seeking to discover the root of what was deemed "perverse" and "hermaphroditic," intersex bodies were anatomically dissected with obsessive precision (Dreger, 2000)—a precision later employed by Freud analyzing the sexual libido using psychoanalysis as his scalpel. Sexologists divided human sexual behavior into "types" of sexual variations that were meticulously documented and methodically pathologized, the legacy preserved in current diagnostic systems. *Psychopathia Sexualis* (Psychopathy of Sex), by Richard von Krafft-Ebing (2011), was the first book to examine "sexual deviations" cataloguing and defining "perversion," including homosexuality. Although it is often stated that homosexuality was removed from the DSM in 1973, the final residual category was not removed until the DSM-5 in 2013 (American Psychiatric Association, 2013). The DSM-IV-TR (American Psychiatric Association, 2000) included a category Sexual Disorders Not Otherwise Specified

[NOS], which listed three items, the last one was, "Persistent and marked distress about sexual orientation" (p. 582). As Lev (2013) stated, "…ostensibly this could be used for anyone struggling with sexual orientation, though I suspect it was not often used for heterosexuals struggling with their straightness" (p. 291). Rubin (1984) said that both gender and sexuality are "organized into systems of power, which reward and encourage some individuals and activities, while punishing and suppressing others" (p. 309). Diagnostic categories in the DSM-5's Sexual Paraphilia's section include "Transvestic Disorder" (previously Transvestic Fetishism), continuing to pathologize (and sexualize) trans people based on their clothing choices (American Psychiatric Association, 2013).

The seismic and revolutionary cultural wave(s) impacting sexuality in the past 60 years—including the impact of feminism, the sexual liberation movement, and progress toward LGB civil rights—had an enormous impact on the socio-cultural environment, but little impact on scientific studies of actual sexual practices. Helen Singer Kaplan (1974) and Masters and Johnson (1966), the first modern sex researchers, presented a more expansive vision of human sexuality; yet, neither mentions the existence of erotically marginalized people in any depth, nor how their models of sex therapy might be adapted for people of trans identities. Models of human sexuality remain heteronormative in belief and practice, and "normal" human sexuality is assumed to include sexual intercourse with a penis and vagina (always leading to orgasm, of course). The "obsessive genital focus" (Tiefer, 2001, p. 39) of most research is steeped in heteronormative assumptions.

Despite sociological and anthropological studies of cross-gender experience that reveal a long historical record of human beings across the globe expressing complex and multi-gendered identities (and presumably having equally complex sexual experiences), contemporary research into gender identity and sexuality was developed within a medical model that has viewed TGNBQ people through a pathologizing lens. The discovery, marketing, and ability to synthesize hormones in the twentieth century heralded new possibilities for TGNBQ embodiment; however, even hormone therapy, pioneered by Harry Benjamin (1966) and revolutionary for its time, also firmly embedded transgender health care within the hegemony of the medical establishment. One consequence was the development of a "transsexual narrative" (Prosser, 1998, p. 68), an autobiographical testimonial, restrictive in scope, myopic, and the *only* approved narrative of trans experience and identity. Since participants were dependent on the medical professional for approval, these official narratives became blueprints for the only acceptable case histories; trans people repeated these stories to receive the medical treatments they desperately desired. For example, early research on "male-to-female transsexuals"[3] revealed that they were commonly asexual before and after "surgical reassignment" (Benjamin, 1966). Indeed, low sex drive was considered a necessary criterion for a transsexual diagnosis (Lewins, 1995). Given the widespread use of an approved "transsexual narrative," individuals were likely afraid to admit to erotic desires, as such an admission would cause them to be rejected as potential candidates for surgery. Male-to-female transsexuals (who were the focus of most extant research) were expected to be heterosexual post-transition (i.e. women who would have heterosexual relationships with men). Long before same-sex marriage was a legal possibility, trans women were often mandated by gender clinics to divorce their wives in order to receive medical treatments reinforcing heteronormativity and raising critical questions about the veracity of the extant research on trans

[3] When citing older research and theory, we are retaining the language used in the original studies. Changing the language to more contemporary usage, for example, changing "transsexual" to "trans/nonbinary," distorts the historical context and might lead to erroneous conclusions about trans identities. The first time we are using an outdated term, we will put it in quotations, so it is clear to the reader that this is not our preferred term.

experiences, particularly their sexual experiences. How could trans people risk telling the truth about their sexuality, their desires, and how they perceived their identity, if their answers would preclude their access to desperately needed medical treatments (Lev, 2004)?

There is a paucity of research on trans-specific sexuality. Historically, most research data derive from either sociological studies on heterosexual "crossdressers" and their wives gathered from transgender organizations, or post-surgical satisfaction studies (i.e. "regret") for "male-to-female transsexuals" gathered from gender clinics (Devor & Dominic, 2015); sexual practices were never the primary purpose of these studies. Research has been conducted almost exclusively by cisgender people (Namaste, 2000), and research participants were almost exclusively "white, urban, middle- and upper-middle-class transfeminine people" (Vecolli, 2014 as cited by Devor & Dominic, 2015, p. 186). More recent research of trans people who are living with HIV has revealed that a disproportionate number of trans women of color are HIV+ (Baral et al., 2013; Garofalo et al., 2006; Herbst et al., 2008); however, it is likely that people of color who are living in poverty have been overrepresented in these clinic-based urban studies (Devor & Dominic, 2015).

The extant research of those assumed female at birth attests to the relative stability and longevity of intimate relationships for trans-masculine people throughout their transition (Fleming et al., 1985; Meier, Sharp, et al., 2013); yet, there is scant research on their sexual practices. There are even fewer studies into the sex lives of those who identify as NB or genderqueer, or of the impact of race, ethnicity, class, aging, or disability on transsexual experience. Complicating any analysis of extant research is the fact that concepts are defined and operationalized differently across studies, with older research utilizing outdated and offensive terminology; given the wide diversity of people with gender-expansive experiences, it remains difficult even to identify the parameters of who is being studied (Namaste, 2000). It is also important to remember that a significant amount of research on trans lives is limited to studying their medical transition and/or surgical processes ignoring the intense psychosocial issues that can impact family relationships, employment, and mental health stability during transition (Lev, 2004). Although transition is certainly a significant life process and focal point within the larger lifecycle, it is likely not representative of the lifelong experience of trans people post-transition, especially regarding their sexuality, desire, and embodiment. By way of analogy, it would be like focusing exclusively on the challenges of puberty when working with mature adults in therapy.

Diversity of Sexual Practices, Orientation, and Embodiment for TGNBQ People

Affirming TGNBQ sexuality requires a sex-positive approach toward sexual health which views all consensual sexual acts as healthy; it encourages sexual pleasure, sexual experimentation, and supports increased sex education. Tompkins (2014) states that, "A sex-positive trans politics that recognises and celebrates diversity in identities, bodies, and constructions of sexual relationships cannot develop in communities without conversations about trans sexualities and trans sex" (p. 776). Sexual health, as defined by the World Health Organization, includes many aspects of human sexuality involving physical, mental, emotional, and social well-being. It includes pleasure, body integrity, romance, eroticism, gender, sexual orientation, reproductive prevention, management of HIV and other STIs, and freedom from sexual coercion and violence (World Health Organization, 2019). TGNBQ sexualities exist at a complex intersection of gender identity, sexual orientation, and sexual desire. Sexual embodiment emerges where gendered bodies can be expressed in a "seemingly limitless array of combinations" (Devor & Dominic, 2015, p. 188). This is, of course, true for cisgender people as well as transgender people, who may or may not embrace binary definitions of their bodies and identities. Additionally, both cis and trans people can express multiple sexual orientations—gay/lesbian, straight, bi/pan, ace/demi—and many different structures for their sexual relationships (monogamous or

polyamorous; Devor & Dominic, 2015; Lev & Nichols, 2019; Rossman et al., 2019). Models of sexuality (Basson, 2000; Iasenza, 2010; Kleinplatz, 2012; Tiefer, 2012) have continued to expand and diversify, incorporating increasingly nuanced sex-positive views of the lived sexual lives of women, lesbians, gay men, polyamorous, kinky and queer people; any discussion of transsexualities must incorporate all of these expanded views.

The desire for particular categories of gendered or sexed people may not be the best way to describe the complexity of any human sexual desires, but the notion is especially confounding when examining the erotic and intimate relationships of TGNBQ people and their sex partners. Theories of sexual orientation are built on a concept of "same" and "opposite" sex partners (i.e. homosexual and heterosexual), a binary based on biological dimorphism, raising the question: the "same" as compared to what? (Lev, 2014). This worldview assumes that the biological similarity or dissimilarity of human bodies is a salient feature of the relationship. Currah (2001) stated that the term sexual orientation "remains intelligible only if sex and gender remain relatively stable categories" (p. 182), and TGNBQ identities disrupt the stable boundary of both gender and sexual orientation. The concepts of "heterosexual" and "lesbian and gay" are inadequate to describe the sexual experiences of those engaging in intimate and sexual behaviors (Lev, 2014). Binary views render invisible bisexual and pansexual people, and enforce a belief that sexed bodies are easily identified by codified categories of sexual orientation. An understanding of one's sexual orientation is grounded first in having a relationship with one's own gendered body (Lev & Nichols, 2019). Bettcher (2014) suggests that "sexual orientation must be reconceptualized to include a core gender-inflected erotic self in addition to a persistent attraction to a type of gendered persons" (p. 618). Sexual orientation is not, in Bettcher's perspective, just erotic energy toward another body, but also the knowing of one's erotic self, which includes one's experience of their own gender.

The power of cultural heteronormativity influences sexual orientation for all people, but impacts trans people in complex ways (Iantaffi & Bockting, 2011). Many trans men and women identify as heterosexual (Devor, 1997; Samons, 2009), although trans people in general also identify as lesbian, gay, or bisexual (Grant et al., 2011; Iantaffi & Bockting, 2011). A wide range of sexual attraction and behaviors have been revealed for TGNBQ people (Bauer et al., 2013; Bockting et al., 2009; Devor & Dominic, 2015), including relationships with heterosexual, bisexual, and lesbian women, as well as gay or bisexual men. Increasing numbers of people are identifying with newly emerging labels, including queer (Grant et al., 2011; Kuper et al., 2012; Williams et al., 2016). Meier, Pardo et al. (2013) report that queer was the most common sexual identity label reported by trans-masculine responders. Rankin and Beemyn (2011) noted approximately one-third of their respondents identified as bisexual and another third identified as lesbian or gay post-transition. Words that research participants used to describe themselves include "transgender lesbian," "heterosexual lesbian," "lesbian with bisexual leanings," "omnisexual," "attracted to genderqueer people," and "bisexual when dressed in female clothes otherwise heterosexual." A meta-analysis of the extant research on treatment outcomes challenges the longstanding myth that most trans people are heterosexual post-transition, which—as described below—was once a criterion for receiving medical treatments. Significantly, this research shows that sexual orientation has no influence on the outcomes of transition-related health care for trans adults (Neider et al., 2016), putting to rest any residual expectations of heteronormative outcomes as necessary for medical transition.

The last decade has witnessed the cultural acceptance of a broad expanse of gender identities and expressions, linguistically as well as sociologically (Monro, 2019). It is important, however, to remember that although terminology has expanded in recent years, and the term NB and the use of gender-neutral pronouns are increasingly common in the lexicon, research exploring the concept of blending gender and chronicling expressions of androgyny has been documented in

the literature for decades (Kane-Demaios & Bullough, 2005; Nestle et al., 2002), as has the diversity of sexual orientations and expressions for trans people (Daskalos, 1998; Schroder & Carroll, 1999). Indeed, language and identities like butch (or stud) lesbians or crossdressing (men) are indicators of gender expressions outside of the binary that existed in previous generations. Butch lesbians, assigned female at birth with masculine gender expressions, have existed with a wide spectrum of identities and experiences from strong lesbian identities, to trans-masculine identities (Cromwell, 1999; Halberstam, 1998). Ignoring this history, as well as their current manifestations, erases the rich possibilities of gender expressions that exist(ed) within working-class cultures and communities of color (Kennedy & Davis, 1993; Lev, 2008; Levitt & Hiestand, 2005). Crossdressing men, a category rarely identified in contemporary research, were historically perceived to be heterosexual males, who did not desire hormones or surgery, although research has revealed that they expressed diverse sexual orientations and varying degrees of desire for medical and surgical transition (see Lev, 2014). Ekins and King (2007) revealed a wide spectrum of patterns of gender mobility, and alternatives to the traditional transsexual narrative of permanently migrating from one side of the binary divide to the other, including those who mix or blend gender, those who oscillate or move back and forth from one gender to the other, and others who attempt to erase their sexed body. Rankin and Beemyn (2011) note that few trans people under 40 label themselves crossdressers, and few over 40 label themselves genderqueer showing a strong generational cohort effect (Lev & Nichols, 2019). Wider options for fluid identities flourish in contemporary Western societies; however, trans individuals who represent a more binary view of transition still very much exist and seek services. As Tobin (2003) has said, "trans people come in more or less the same variety of sexual orientations as non-trans people" (para. 27, part I).

Sexual Challenges

Sexual dysfunction has been viewed as involving four specific areas, including a lack of desire or interest, arousal dysfunction, orgasm and/or ejaculatory dysfunctions, and pain during sexual activities (McCabe et al., 2016), although focusing on sexual dysfunction and "performance" rather than "embodiment, connection, and integration" (Kleinplatz, 2012, p. 103) is in and of itself problematic. Sexual dysfunction is multidimensional, and when working with TGNBQ people, sex therapy also requires looking at sexual scripts (Simon & Gagnon, 1986), issues of shifting sexual orientation, the effects of medical and surgical treatments, and the impact of gender dysphoria on body image (Holmberg et al., 2019). Genitalia are a (if not the *the*) prime signifier of sex and sexuality, so having bodies that do not simply match felt that gender identity is often a source of distress. Some TGNBQ people may feel uncomfortable being naked with a partner (or even alone), and have difficulties having their body touched (Bettcher, 2014); they may avoid sex or prefer to have sex in the dark (Iantaffi & Bockting, 2011). Questions may arise about whether they feel comfortable using the body parts that they have (Williams et al., 2016), for example, to penetrate a partner with a penis that may not match how they wish to see their body, and may evoke gendered sexual behavior they eschew.

Williams et al. (2016) say that "given the disjunction between their felt gender identity and the material reality of their sexed bodies," some trans women have difficulty "erotically activating their bodies" (p. 1667). TGNBQ people often experience dislike or even disgust about their genitalia, as well as confusion about their sexual role, behavior, or expression, due to gender dysphoria (Lev & Sennott, 2012). Research has shown that for some trans women, passability and being seen and perceived as cisgender increase their sense of feeling attractive. Williams et al. (2016) say, "Not only do they have to deal with aspects of their body that do not correspond with their gender identity, but they also must meet the higher standards of attractiveness applied to [cisgender] women" (p. 1667). Trans women's sexual fantasies may focus on their femininity, or

having a traditional female body; this is especially true in the beginning of transition (Serano, 2007). Trans men also fantasize about gendered embodiment (Langer, 2016; Prosser, 1998, Ramachandran & McGeoch, 2008), including wanting/having a penis.

Although it may seem obvious that TGNBQ people often struggle with genital dysphoria, it may indeed surprise those who only see pathology in trans bodies to recognize that many TGNBQ people enjoy and celebrate their often-complex bodies. Through the use of linguistic exploration, gendered assumptions about the body can be deconstructed and language can challenge heteronormative and cissexist socio-cultural ideologies about natal "male" and "female" bodies. Edelman and Zimman (2014) say that, "language not only reflects but also acts to constitute the gendered meanings applied to the body because social meanings do not exist prior to their semiotic referentiality" (p. 681). The terminology that TGNBQ people use to name their genitalia and body parts is a conscious act of naming and defining themselves.

TGNBQ people often rename their body parts—an interpretive practice of redefining, and remapping their erogenous zones, genitalia, and sexed body parts—so they are congruent with felt gendered identity (Hill-Meyer & Scarborough, 2014; Williams et al., 2016). Schrock et al. (2005) refer to this as "a reflexive trans embodiment." A testosterone-enlarged clitoris may be renamed, and indeed resignified, as a penis (Riggs & Bartholomaeus, 2018; Tobin, 2003), or a vagina may be named a "manhole" (Hale, 1997), so that it is re-gendered and uncoupled from their common associations. Williams and colleagues (2016) share a trans woman's experience of her anus; she says, "It's female too. I mean it could be male or female" (p. 1671). Indeed, some trans-masculine folk refer to what is often thought of as female genitalia (i.e. a vagina) as a "bonus hole" or extra hole, or they mix the typical male/female referential language (i.e. "boy-cunts"). These mixed gendered bodies are not the source of shame but rather integration and embodiment.

Embodiment, however, is about more than the name of a body part; in one study, 60% of trans-masculine people experienced a "phantom" penis at some point in their lives (Ramachandran & McGeoch, 2008). Researchers historically dismissed these experiences as delusional; however, the renaming of body parts serves a healthy psychological process that assists in bodily attunement (Lev, 2014). Indeed, certain elements of gender may "begin their residence in body schema," as a healthy way to process and internalize authentic gender experiences, and to replace the gender-incongruent mirroring trans people often experience from their external bodies (Langer, 2016, p. 313). Creative efforts to explore these sexual and embodiment challenges include the use of gaming, cybersex, fantasy, role-playing, cos-play, and science fiction venues (Hansbury, 2011). Additionally, many TGNBQ people enjoy bondage, discipline, sado-masochism (BDSM) and "fetish" sexual practices, which allow for expansive sexual role-playing possibilities (Bauer, 2008; Hale, 1997; Tobin, 2003; Tully, 1992).

There are TGNBQ as well as cis people who are specifically eroticized by trans bodies. Heterosexual and cisgender people may occasionally experience desire (Reback et al., 2016), and might also develop desire over time with a partner who is transitioning (Samons, 2009). However, those who are explicitly attracted to trans people are often derided as exoticizing and fetishizing trans bodies and sometimes referred to as "tranny-chasers." Tompkins (2014) challenges us to bring transsexualities "into a sex-positive arena of language, practice, and erotics that celebrates trans identities and bodies and makes it acceptable to speak the erotics of trans in sex-positive and affirming ways" (p. 774). Given the challenges of how trans people have been exoticized and fetishized (and often the victims of sexual violence because of this), we must not fall into the trap of not acknowledging TGNBQ people as erotic and sensual, which can be viewed as negating their specific desirability.

Recent research shows that the majority of TGNBQ people are dating, and have had romantic and sexual experiences; however, only one-third stated sexual satisfaction—those who were

partnered identified as more sexually satisfied than those who were single (Callander et al., 2019). TGNBQ people who are single may experience rejection when seeking out intimate relationships, and even though there are bars, community centers, and internet dating sites that are specifically welcoming to TGNBQ people, isolation is an all-too-common experience. Revealing one's gender identity to a new sexual partner can have negative consequences, and strategic decisions about how, what, and when to disclose are often a source of anxiety (Devor & Dominic, 2015; Iantaffi & Bockting, 2011).

Trans people state that they often do not feel respected when dating online, and many find limitations in the gender options available on most dating apps, especially for those who identify as NB (Callander et al., 2019). For those who are partnered before they came out or began a social or medical transition, there are many challenges that can impact sexuality. As mentioned earlier, it was historically assumed that being trans was reason enough for a spouse to end a long-term marriage. Shocking to a modern viewpoint, transition protocols once expected trans people to divorce their spouses as part of the standard procedure to be approved for medical and surgical treatments (Clemmensen, 1990). This clinical stance led to increased isolation for trans people and the severing of familial ties and parental relationships. The fact that clinicians could not even imagine spouses wanting to remain together speaks to the underlying assumptions and prejudice toward TGNBQ people and their intimate partners. It is only recently that narratives have been revealed and protocols been developed to assist couples with a trans partner to remain together (Constantinides et al., 2019; Erhardt, 2007; Lev, 2004; Malpas, 2006). As discussed earlier, shifts in sexual orientation during and following transition are very common, but there has been little research to date on the impact of transition on couples that were previous gay male identified, and/or couples where the trans-masculine partner was in a heterosexual relationship, so clinical focus has mostly been about both trans women and trans men involved with cisgender women.

It is not uncommon for transfeminine people in heterosexual relationships to struggle with sexual problems (Samons, 2009; Tully, 1992), related in part to their partners' reluctance to engage in "lesbian" sexual practices and intimacy. Historically, cis-female, heterosexual partners have identified a decrease or lack of sexual arousal toward their partner's feminine gender expression (Docter, 1988). However, partners who continue their exploration may find themselves sexually excited by the gender transition (Erhardt, 2007; Samons, 2009). Some of the difficulties partners identify are related to sexual functioning; other difficulties involve frustration with their partner's preoccupation with what they perceive to be "stereotypical femininity" or refusal to act "like a man" (Boyd, 2003). The partner's libido also might diminish, however, if she cannot welcome her partner's female self—and she often simply cannot—leaving both partners with unmet sexual needs. Boyd (2003) debunks the facile assumption that there are two kinds of partners, "the ones who accept their husband's cross-dressing and those who don't" (p. 52). She says that a person may be both types "depending on the day or the week or the moment" (Boyd, 2003, p. 52), and this can certainly impact sexual intimacy and relationships as a partner's comfort or sexual interest vacillates. For female partners who were in heterosexually defined relationship pre-transition, the loss of heterosexual privilege can be shocking and they may be unprepared for the serious social challenges invoked by their partner's public transition.

Although trans-masculine people and their partners also experience complex relational challenges during transition, research has shown that relationships often remain stable both during their transition and afterward (Fleming et al., 1985; Kockott & Fahrner, 1987; Meier, Sharp, et al., 2013). For trans-masculine people, there may be little shift in their social or sexual masculine gender expression, and for cisgender female or femme partners, this masculine aesthetic was one they always found attractive. The public masculinity of masculine-of-center, queer, or butch-identified partners is often viewed as sexually exciting. Although erotic crossdressing

in males has long been recognized, female crossdressing has been an unacknowledged area of study; it has been suggested that this area remains unexplored because male clothing holds no erotic attraction for females (Ettner & Brown, 1999). However, the use of male clothing in lesbian culture as a way of expressing masculine identities has been consistent throughout queer and lesbian history. Female crossdressing in the BDSM and kinky sex subcultures (Hale, 1997) and among drag kings (Volcano & Windh, 2005) is evidence that there exist erotic aspects to female masculinity and crossdressing (Halberstam, 1998).

When butch or masculine females begin to transition, their queer or lesbian-identified partners, especially those who are femme-identified, often face unique psychological challenges to their identity (Brown, 2010; Mason, 2006). Having a partner with a male identity and who is using male pronouns can bring unexpected heterosexual privilege; a lesbian-identified partner may be more likely to reject than embrace being perceived by others as heterosexual. For lesbian-identified women, losing membership in the lesbian community can be very emotionally challenging.

Shifts in gender identity or expression, physical embodiment, and potentially sexual orientation can certainly be destabilizing not in the least because they disrupt heteronormative assumptions, as well as conventional assumptions about same-sex sexuality. Sexual partners often find that they must "consciously negotiate and articulate the meanings of their sexual identities and sexual interactions" (Devor & Dominic, 2015, p. 190) and "recalibrate their own understandings of their mutual sexual activities, and of their own sexual identities" (Devor & Dominic, 2015, p. 192). As Williams et al. (2016) suggest, "A suitable intimate partner…would be one willing to negotiate sexual practices and positions that are acceptable to both and adapt to the exigencies of a non-traditional body" (p. 1668). It is to be assumed that sexual practices will shift and change during a gender transition; however, when TGNBQ people feel that their gender identities are being correctly acknowledged by their partner(s), this will often increase their sexual confidence, and perhaps their interest in being sexual and feeling desired (Brown, 2010; Devor & Dominic, 2015).

The Impact of Medical Treatments for TGNBQ People

Medical and surgical treatments can impact physiology as well as psychology, and have predictable effects, both positive and negative on sexual satisfaction. Holmberg et al. (2019) define sexual satisfaction as "the affective response to the individual's expectations or evaluation of the balance of negative and positive dimensions of someone's sexuality and is more than simply sexual function" (p. 122). Hormonal treatments can have a dramatic effect on sexual desire (Hill-Meyer & Scarborough, 2014), and Callander and colleagues (2019) found that some TGNBQ people altered their hormone regimens to increase or decrease their sexual desire or functioning, and were largely satisfied with the results.

Hormonal treatment for trans women commonly includes taking both exogenous estrogens and anti-androgens. This can have positive and desired effects on the development of a more feminine-presenting body, including the growth of breast tissue and the softening of their skin, as well as potentially less desirable effects, including a lessening of sexual desire and functioning, diminishing erectile function, and increasing difficulty achieving orgasms (Devor & Dominic, 2015; Holmberg et al., 2019; Nikkelen & Kreukels, 2018; Serano, 2007, Wierckx et al., 2014; Williams et al., 2016).

Trans-masculine people also experience positive effects of hormone treatment and masculinization of their bodies, including deepening of their voices and increased bodily hair, as well as increased sexual arousal and enlargement of the erectile glans due to the effects of testosterone (De Cuypere et al., 2005; Devor, 1997; Green, 2004; Valerio, 2006; Wierckx et al., 2014). Acne and male-pattern baldness may also be experienced and are not commonly as welcomed.

Research has consistently shown that trans men and women identify sexual fulfillment following surgical transition, which was historically the only time when sexual satisfaction was assessed (De Cuypere et al., 2005; Pfäfflin & Junge, 1998). However, not all TGNBQ people seek surgical treatments, and some desire to have surgery but have not yet done so influencing sexual satisfaction, bodily comfort, and general psychological well-being (Nikkelen & Kreukels, 2018).

It is not surprising that sexual satisfaction and post-surgical adjustment often hinge on the success of the surgical result, which continues to improve as the surgical techniques for sex reassignment are refined (De Cuypere et al., 2005; Pfäfflin & Junge, 1998; Schroder & Carroll, 1999). Follow-up studies of trans women show that post-surgical psychological well-being is related to the success of surgical results (Pfäfflin & Junge, 1998), including the physical look of the external genitalia (Ross & Need, 1989). Recent studies seem to indicate that as affirming surgical techniques have improved, patients are reporting increased sexual satisfaction (De Cuypere et al., 2005; Pfäfflin & Junge, 1998). Schroder and Carroll (1999) found higher levels of sexual satisfaction with improved appearance, vaginal depth, and sensation, which can vary depending on surgical technique. Research has shown that trans women experience orgasms following surgical transition (Lawrence, 2003; Schroder & Carroll, 1999). Emerging research reveals a reduction in the utilization of mental health treatment following surgery (Bränström & Pachankis, 2019). However, surgery can also be associated with sexual sequelae, including post-surgical pain or complications, physical limitations or constraints of the neo-genitalia, and psychological challenges of having a new body (even one that was very much desired) (Holmberg et al., 2019).[4]

Genital surgeries for trans-masculine people have historically been prohibitively expensive (Rachlin, 1999), especially before these were covered by some insurance companies, and some genital surgical procedures are very invasive, requiring a prolonged healing period (particularly phalloplasty with urethral extension). Many trans-masculine people do not pursue genital (also known as "lower" or "bottom") surgeries, for personal, medical, or financial reasons, and have affirmed stable male gender identities without genital surgery (Fleming et al., 1985; Kockott & Fahrner, 1987), and have, to some extent, redefined social norms of masculinity and manhood (Green, 2004; Kotula, 2002; Vanderburgh, 2007).

The internet has fostered communication and community building for TGNBQ people (Lev, 2006), which has increased access to medical and health-related information; youth in particular often rely on the internet in seeking out health care information, particularly YouTube (Riggs & Bartholomaeus, 2018). However, information on the internet may or may not be accurate, and access to affirming trans-health care remains limited. Many TGNBQ people receive inadequate information on reproductive health care, fertility preservation, and/or conceptive care, sometimes resulting in unwanted pregnancies (Callander et al., 2019; Riggs & Bartholomaeus, 2018; Veale et al., 2016). NB-identified people experience particular challenges accessing medical and surgical care (Callander et al., 2019; Schuylenbergh et al., 2018). Erroneous assumptions about trans-masculine sexual behaviors may lead to inadequate testing of STIs (Reisner et al., 2014; Sevelius, 2009). Although prevalence rates for sex work among transfeminine women and NB people are high (Bauer & Hammond, 2015; Grant et al., 2011), there is a paucity of research on how this may impact sexuality or sexual health.

For TGNBQ people who take exogenous hormones, and/or have had various surgeries, the effects of these medical procedures on their sexual health interface with their sexuality. Having unique physiologies may increase unique medical dilemmas, which can, in turn, lead to potential

[4] See Holmberg et al. (2019) for a comprehensive overview of the effects of both hormonal treatment and surgery on sexual satisfaction and orgasms

health complications. Examples include a post-surgical trans woman who is still susceptible to prostate problems, including cancer, and trans men who still have a uterus can become pregnant despite being on testosterone and not experiencing a menstrual period. This can confuse medical personnel not experienced working with TGNBQ people, and can exacerbate gender dysphoria for the individuals themselves.

Queering Sex Therapy with TGNBQ Clients

Sex therapists are seeing more NB sexual and gender landscapes, and supporting trans and cisgender people alike who are coming out as NB in their lives and sexual relationships. This means that therapists need to be able to engage in thinking that is not mired in the binary, which is an either/or, good/bad, male/female, gay/straight way of conceptualizing identities. It also means that therapists need to be aware of the complex nuances of different kinds of polyamorous, consensually non-monogamous, and open relationships, and educate themselves about these relational orientations without expecting their clients to do all the work. This requires the therapist be able to hold each coming out with both singular importance and an understanding of how each new identity influences other new identities. Working collaboratively with clients, the therapist can help name all the intersecting identities within the relationship, explore each identity to increase language and communication between the partners, and examine their fears and concerns that these changes may bring into their relationship.

In the past three decades, socio-cultural understandings and trans activism regarding TGNBQ identities have nurtured a tsunami of paradigm shifts, transforming the political landscape and heralding in a re-evaluation of psycho-medical paradigms that pathologize trans identities. Treatment models are now being initiated and advanced that are respectful of diverse TGNBQ expressions, incorporate family and couple issues, honor young transitioners, respect diverse family forms, and address post-transition identity and relationships. Every major social work/psychology professional organization has made bold policy statements supporting TGNBQ people, depathologizing trans-health care, and calling for an end to gatekeeping and discrimination. However, the erotic lives of TGNBQ people remain underexplored and rarely clinically examined. The research has only peripherally focused on issues related to family life, intimacy, and sexuality.

Kleinplatz (2001, 2012) has critiqued the field of sex therapy on a number of grounds, stating that it tends to emphasize performance rather than subjective meaning and experience, marginalize diversity rather than embracing it, and promote conformity to a toxic norm rather than support social change. She says that we assume a "norm that involves two able-bodied heterosexuals in a monogamous relationship" (2001, p. 116) and challenges sex therapists to not settle for less than "erotic transformation" (2012, p. 116).

Iasenza (2010) has invited therapists to *queer* therapy, to queer the consulting room in order to "create [an] expansive erotic space by inquiring about, exploring, and, if necessary, normalizing and reframing queer experiences" (p. 298). It is only within a queered clinical context that we can co-create an environment that includes relational possibilities outside of a two-gendered binary, beyond heteronormativity (Constantinides et al., 2019; Lev, 2014; Lev & Sennott; 2012; Nichols & Shernoff, 2007). Queering therapy also means moving away from an individual concept of gender and sexuality to one that is more relational, because as Malpas (2006) has said, "sexuality is gendered and gender is relational" (p. 201). Iasenza (2010) recognizes that gender transpositions and genderqueer fantasies, as well as internalized shame regarding these feelings, are important to explore in all sexual pairings, not just those that are identified as LGB/TGNBQ. Queering therapy encourages sex therapists to also recognize the queer possibilities inherent in heterosexual, opposite-gender sexuality.

A Sex Therapy Model for Working with TGNBQ People

Our sex therapy model for working with TGNBQ people is founded on three interlocking theoretical positions. The first is understanding the developmental process of TGNBQ identity development (Lev, 2004). The second is a transfeminist approach (Koyama, 2003) which assumes that everyone should be entitled to name their own identity, to make decisions about their bodies, and to have those bodies be respected and protected from violence. The foundational principles of the transfeminist therapeutic approach are as follows: (a) there is no hierarchy of authentic lived experience for women; (b) privileging one type of womanhood or femaleness over another is inherently anti-feminist; (c) no one individual, group, or type of woman is permitted to define what it means to be a woman; and (d) most TGNBQ individuals have had lived experience, either past or present, as a girl or woman and have suffered the direct repercussions of socially condoned misogyny and systemic gender-based oppression (Sennott, 2011). And finally, the third is a systemic, relational, and narrative theory with an emphasis on alliance building and attunement for both TGNBQ clients and cisgender partners (Constantinides et al., 2019; Iasenza, 2020; Malpas, 2006). From the foundation of these theoretical positions is born a three-pronged practice approach; clinicians are expected to have self-awareness about their privilege and power, engage in self-education through seeking specialized supervision and consultation related to intersectional understandings of TGNBQ sexual health and practices, and offer transparency with clients to develop trust and accountability in the therapeutic relationship.

Affirming TGNBQ sexuality and sexual practices also requires a sex-positive approach toward sexual health which views all consensual sexual acts as healthy; it encourages sexual pleasure, sexual experimentation, and supports increased sex education. Tompkins (2014) states that, "A sex-positive trans politics that recognises and celebrates diversity in identities, bodies, and constructions of sexual relationships cannot develop in communities without conversations about trans sexualities and trans sex" (p. 776). Sexual health, as defined by the World Health Organization, includes many aspects of human sexuality involving physical, mental, emotional, and social well-being. It includes pleasure, body integrity, romance, eroticism, gender, sexual orientation, reproductive prevention, management of HIV and other STIs, and freedom from sexual coercion and violence (World Health Organization, 2019).

Like all humans, TGNBQ people struggle with sexual problems, sexual dissatisfaction, and orgasmic difficulties, as well as specific social, political, and assaults that negatively impact their sexual lives (Lev, 2014; Lev & Sennott, 2012). Additionally, there are unique stressors that TGNBQ people face when dating, forming partnerships, developing intimacy, or seeking to begin families that are specifically associated with sexuality and embodiment. Other stressors may not be as directly related to sexuality but may affect it, such as medical treatments, medical costs, job security, parenting, and social scrutiny, as well as the physical limitations from aging or chronic illnesses.

Despite these challenges, many TGNBQ people do successfully navigate these difficulties and maintain or create significant, ongoing, intimate relationships. However, when TGNBQ people and their partners seek help from professionals, particularly assistance with sexual problems and issues related to intimacy, they may find few providers, even those who are sex therapists, trained to assist them.

Sex therapy with TGNBQ people and their sexual partners is a newly developing field. Queering sex therapy, like all good sex therapy, requires a thorough and comprehensive biopsychosocial sex assessment that includes specific questions about TGNBQ identities (Holmberg et al., 2019). Therapists need to assess where people are in their transition process because sexuality issues that arise when someone is just beginning to come out as TGNBQ may be very different from those that emerge after starting cross-sex hormones, and different still from those

following gender-confirming surgeries; body dysphoria as well as embodiment can dramatically shift over time, including changes that involve transition but occur well past initial transition.

Coping with intimacy, honesty, communication, and changing bodies over time are, of course, universal concerns familiar to all relational therapists. When working therapeutically with TGNBQ individuals and their partners, therapists must honor and celebrate the desires of each partner equally and not assume that relational discomfort or discontent is directly linked to the transition. Effective sex therapy with TGNBQ people and their intimate partners must foster sexual communication that allows for the multiple experiences within changing bodies and erotic desires. The therapist must create a holding environment that can contain both the negative emotionality and anxiety caused by the changing identities and bodies, and the possibility of future sexual satisfaction (Iasenza, 2010).

TGNBQ people are spouses, lovers, and partners, as well as single and poly individuals who actively seek sexual, romantic, and relational intimacies. They have partners who are cis as well as partners who are TGNBQ (Devor, 1997). Although the sexual issues for trans people and their partners may be somewhat unique, as Docter (1988) says, "they are by no means entirely different" from other issues that couples bring to therapy (p. 181). It is an exciting challenge to effectively queer sex therapy in order to provide skilled and competent care for TGNBQ people and their partners.

Identifying Therapeutic Needs of TGNBQ Individuals and Their Partners

The therapist's role in supporting TGNBQ sexuality and practices are three-pronged: self-awareness, self-education, and transparency. In order to foster a TGNBQ person's self-definition of their own gender, therapists must be knowledgeable and supportive of diverse gender identities and expressions, as well as understand their own personal relationship to gender and sexuality. The process of self-awareness, self-education, and transparency will enable therapists to bring language and understanding to the experiences of transition and help them communicate about sexual desires and practices within intimate relationships. Providing therapy for TGNBQ people and their partners requires an understanding of the person's gender emergence and their partner's experiences, as well as the dynamic relational process that emerges for the couple (Constantinides et al., 2019; Lev, 2004; Malpas, 2006). In addition, therapy based on models that incorporate empowerment, advocacy, and transfeminist principles creates a safe environment for the couple to explore the development of intimacy and sexuality (Constantinides et al., 2019; Sennott, 2011).

Self-awareness on the part of the therapist is the first component of a strong therapeutic connection with TGNBQ clients. It is important to be aware of one's reactions stemming from personal beliefs. If a therapist comes to a personal impasse regarding aspects of TGNBQ identities, the clinician ought not subject clients to this impasse but should seek out supervision with a trained gender and sexuality supervisor who is also familiar with marital and family issues or refer the couple to someone who can provide affirming gender and sexuality treatment. A personal impasse for a clinician that would not be supportive to a client are feelings of prejudice or judgment that are morally or ethically based. These prejudices are harmful to the TGNBQ person's identity development and should not be shared with the client. Instead, these feelings ought to be addressed in supervision as countertransference concerns. If the clinician cannot move through these feelings, they would be expected to find a therapist for the client who would not struggle to affirm the TGNBQ person in their gender and sexuality.

If the discomfort a therapist feels is based on a lack of knowledge, then self-education can be the most effective way to move forward. Educating oneself does not mean asking the client to be the educator; this can feel re-traumatizing for some TGNBQ people. A clinician's discomfort

in talking openly about sex in general and queer, trans, and NB sexualities in particular can add to the oppressive dynamic in the therapeutic relationship. It is constructive to destigmatize TGNBQ sexualities with clients, so they can approach communication with their partners more easily (Constantinides et al., 2019; Lev & Sennott, 2012). The therapist models a depathologizing approach, which encourages relational honesty and openness between the partners, taking a stance of affirming curiosity while mirroring the language used by clients regarding sexual identification, names of sexual practices, and body parts. Therapists can help clients to express their feelings of betrayal when pronouns are misused and repair damage created within the therapeutic relationship. This models and fosters successful communication around other difficult topics (i.e. sexuality and sexual practices, gender identity differences, and polyamorous and consensual non-monogamous practices), not only in therapy but also with partners and family members. This approach reframes an individual problem into a normative relational adjustment (Lev & Sennott, 2012; Malpas, 2006).

Lastly, when working clinically with TGNBQ clients, transparency is vital to the therapeutic alliance. After the therapist has explored issues of self-awareness and has engaged in self-education, it is the relational action of transparency that indicates to clients that the therapist does not assume any specific narrative of TGNBQ lived experience (Constantinides et al., 2019; Malpas, 2006). Each relationship is going to experience transition differently, in part because of the TGNBQ partner's identity and experience, and in part because of the particular dynamics of that relationship. This approach will allow a more complex and individualized story to emerge and also aid in integrating past identities with present and future experiences, as well as disclosing fears about any physical or social transitions. The transparency of the therapist's unique reactions and experiences to the emerging narrative can communicate to clients that they do not need to fit into a typical or predetermined TGNBQ life story. Transparency with clients is a blending of psychotherapy, notions of alliance building, and the ethics of social justice and feminist practice, that is, the transfeminist therapeutic approach (Constantinides et al., 2019; Lev & Sennott, 2012; Sennott, 2011).

TGNBQ people who are in the early stages of recognizing and affirming their gender identities often begin to build a support system by confiding in a loved one about the feelings they are having. The partner or spouse of a TGNBQ person will often move through a predictable developmental trajectory that includes a process of discovery and disclosure, turmoil, negotiation, and finding balance (Lev, 2004). Part of the negotiation stage involves coping with the sexual aspects of intimate relationships, especially when the TGNBQ person's body is changing from the effects of exogenous hormones. The more awareness partners have about their own prejudices and biases related to TGNBQ identities, the more able they will be to connect with their TGNBQ partners on an intimate and sexual level.

Skyler and Jules Skyler, who is white of Italian heritage, and Jules, who identifies as a mixed-race person of color, met in their early twenties during college when they both identified as cisgender gay men. After five years of being together in a monogamous marriage, Skyler came out to Jules as NB and transfeminine. When Skyler first told Jules, they asked Jules to use they/them pronouns. Jules responded that he had always known that these parts of Skyler were present and assured Skyler that he supported their transition to a more feminine and NB presentation and identification. After Skyler began gender-affirming hormones and expressing their gender in a more classically feminine way, Jules realized that he also had some identities that he had not given himself the opportunity to explore. With the freedom that Skyler was modeling, Jules was able to explore his attractions to people with many different genders and sexualities, and that this was what made it possible for him to so clearly understand and support Skyler's transition. Jules realized that he was pansexual and also polyamorous. This

explained how he could stay so attracted to Skyler as Skyler transitioned to a highly feminine presentation, while still also desiring people who identified as men. Skyler and Jules began to renegotiate their relational and sexual agreements and discuss how to move forward with consensual non-monogamy (CNM). Although Skyler was open to CNM practices, they did not identify as polyamorous. Skyler could imagine having other sexual partners, but not having another love relationship with anyone other than Jules. Jules, however, realized that he identified as polyamorous and wanted to pursue other love relationships and also possibly be partnered with other people.

As therapy proceeded, it became clear that Skyler's gender transition was not as threatening to the couple as their relational orientation. Skyler was open to CNM but not to polyamory. Using the Alternative Family Structures Approach (AFSA), created by Shannon Sennott (Constantinides et al., 2019), clinicians are offered a guide for working with erotically marginalized polyamorous clients in an eight-session clinical model. AFSA begins with assessment and agreement components that help determine if a relationship is in crisis and guides the therapist to explore the relational foundations and the romantic and intimate connections in the relationship. The eight-session commitment from clients allows the therapist to support partnerships in creating language to understand new needs related to opening a relationship and to help them create perimeters and agreements for the context of their open relationship. It is easy to see how the therapist working with Skyler and Jules might have felt overwhelmed by the complexities of the intersecting gender and sexuality shifts in the relationship. However, honoring each new identity shift individually slows down the exploration process for both the clinician and the clients, and allows the therapist to listen to what their TGNBQ clients and their partners see as their area of need, not just what draws the therapist's focus.

Ani and Eleanor Ani and Eleanor had been married for over 20 years and had raised two children who were now in college. After their children left home, Ani revealed her trans identity to Eleanor. Eleanor is multi-racial, heterosexual, and cisgender. Ani is Asian-American, and up until this point, had lived as heterosexual and male. When Ani came out to Eleanor and extended family, she self-identified as pansexual and as a trans woman. Previous to Ani's coming out, Eleanor was aware that Ani enjoyed dressing "en femme" as Ani called it; however, Eleanor was shocked to find that her partner had been living for many years as a heterosexual man at the expense of Ani's mental and sexual health. Eleanor was also devastated that Ani had not felt safe to tell Eleanor about her trans identity. Both were committed to maintaining their relationship and worked hard through many layers of shame, betrayal, and disclosure in therapy.

As Ani moved forward in her transition, developing breasts and dressing and expressing herself as a woman, Eleanor was not sure how to continue a sexual relationship with her. Ani remained sexually attracted to women and longed for the experience of being in bed with her wife, as a woman; however, the idea of lesbian sex did not appeal to Eleanor. Ani had not yet pursued any gender-confirming surgeries, partially because of her ambivalence about the necessity of it, and also because of the financial constraints it would place on the family. Taking estrogen had impacted Ani's ability to have an erection, and this left her unsure of how to sexually pleasure Eleanor who enjoyed penetrative sex. This, in turn, caused Eleanor to feel rejected, hurt, and frustrated. Ani and Eleanor wanted to develop new sexual practices that could allow them to maintain their sexual intimacy but they both felt vulnerable and insecure about how to make the other feel pleasure.

Ani was still in the early stages of her own coming out process. Over a period of time, she had begun to express herself as a woman, use a female name and pronouns, and explore feminizing

hormones as a way to actualize her body. She was feeling good about these changes, and excited, but was still vulnerable to rejection, and terrified of losing her marriage, which had a long, successful history. Eleanor wanted to be a supportive spouse, and was less in touch with (or able to articulate) her feelings of ambivalence and lack of erotic desire for Ani, who had been a husband in a heterosexual relationship—one that had deeply satisfied her.

It took Ani and Eleanor a series of difficult conversations in therapy for Eleanor to express her frustration with Ani because she was committed to being an ally to Ani, and she did not want to hurt Ani or be unsupportive. Eleanor did not feel sexual desire for Ani because she was not oriented toward feeling attracted to women. Ani felt that she was still "the same person" that Eleanor loved before transition and she wanted Eleanor to join her in celebrating her authentic self. Since Ani identified as pansexual, and had always been attracted to women, her gender transition did not disrupt her sexual desires or orientation. Both partners were feeling betrayed: Eleanor because Ani had withheld her true self for so many years, and Ani because Eleanor stated support, but was clearly not interested in erotically connecting with her as a female.

Ani and Eleanor's therapist sought out supervision with a sex therapist trained in working systemically with trans couples, and who also worked with sexually marginalized people of color. Through this process, the therapist helped Ani and Eleanor understand that they were both "in transition," a developmental and dynamic process. The clinician was also able to help the couple clarify what repair might look like between them, as both partners felt betrayed in complex ways. The therapist both challenged and supported Eleanor in understanding that there is a way to both intellectually and politically support her partner's coming out process while also honestly attending to her own sadness and grief over the loss of the relational dynamic that was the foundation of their love and romance for the last 20 years. When Eleanor was able to share the complexity of her sadness about the loss and her frustration about not being trusted with Ani's secret, at first Ani could only hear Eleanor's hurt and anger as rejection of her as a trans woman. Their therapist assisted Ani in hearing Eleanor's pain and betrayal, and her fears for her future. She had not sought out this transition, but it was thrust upon her by Ani's coming out; it was not a path she would have chosen. Knowing that Ani had kept this secret from her for 20 years left her reflecting back on their marriage and wondering how well she knew Ani.

The therapist helped Ani develop empathy for Eleanor's struggles, and continued to guide both partners to see the multiple layers of truths for each person, and to stay differentiated and compassionate with one another as they worked together in sessions to build new language and meanings that became a cohesive and shared narrative of their relationship journey. Over time, Ani was able to empathize with Eleanor's situation and see that she was caught in the middle of both loving new parts of Ani and losing other parts of their sexual connection that she deeply missed. With Ani's compassion, Eleanor began to grieve what she had lost because of Ani's gender transition. As the newness of Ani's transition faded, Eleanor was able to become a more attentive and flexible partner as she worked through her loss and sadness. Both partners understood that they were at the beginning of a new sexual and relational journey and committed to therapy as a place to hold themselves accountable and stay in close communication about emotional shifts and sexual needs.

Through clinical consultation, Eleanor and Ani's therapist was able to increase her self-awareness of her own power, privilege, and assumptions regarding trans bodies and sexuality. She was able to be transparent about her process, which allowed for increasing authenticity and alliance building with the couple. Utilizing a psychoeducational lens, she was able to introduce new sexual concepts into the discussion. She asked them: What sexual practices/acts/behaviors

are desired but might feel shameful and can then be named? Can Ani discuss her anatomical dysphoria with Eleanor? How can they rename body parts to be more affirming of Ani's womanhood? Can Eleanor touch Ani's breasts, cupping her breasts and sucking her nipples, instead of seeing it as a male chest? Perhaps Eleanor can interact with Ani's genitalia in a way that honors her female sexuality, by naming them "clitoris" and "vulva."

The therapist introduced ways that both partners might be able to actualize their sexual desires, if they were willing to expand, or *queer*, their sexual practices. When sexual practices are queered, there are identity openings that create sexual spaciousness for partners to explore certain sexual practices that they might have never imagined would be part of their erotic landscape. There were many ways that Ani and Eleanor queered their sexual and emotional relationship over time, finding freedom in their newly inhabited queer life together. Ani found that it was very erotic for her to wear a strap-on with a realistic dildo, and Eleanor was more aroused than she could have ever imagined, to be made love to by Ani in this way. This validated Eleanor's sexual desire for penetration, while still honoring Ani as a woman. Over time, Eleanor realized that she had always known and loved the feminine aspects of Ani before her transition, and now, with her newly queered lens for her relationship, she was much more dominant and bold as a sexual partner than she ever thought she could be when she identified as heterosexual.

Lucas and Sonya When Lucas began his transition, his partner of five years, Sonya, was supportive. They had met on a butch-femme internet community bulletin board, connected deeply as Puerto Rican New Yorkers, and their sexual attraction was built upon the erotic dance of their gender expressions. In the years before Lucas's transition, Sonya was sexually excited by Lucas's androgyny. She loved how Lucas's skin was soft and that he also was very naturally muscular for a female-bodied person. Most of Lucas's life he was treated as a man and although he didn't always blend in as one, he was afforded many male privileges in both of their families. Lucas was often given the roles and duties a man would commonly be given in their traditionally Catholic families. Sonya also understood that Lucas experienced some dysphoria in his body, especially around his chest. He often wore both a binder and a tight undershirt under his t-shirts. About a year before his transition, he stopped getting completely naked when they were intimate, and he asked Sonya to touch his chest "as if he were a man." She asked him what he wanted her to do differently and he told her that it made him feel dysphoric when she referred to his body with words, like "beautiful" or "gorgeous," as he preferred "hot" and "handsome." He also wanted her to touch him differently, and not caress his breasts; he wanted her to be rougher, to treat his chest like a male chest.

When Lucas decided to resolve his dysphoria by having chest reconstructive surgery and taking gender-affirming hormones (i.e. testosterone), Sonya initially shared his excitement in the journey. However, as Lucas's body began to change, including the deepening of his voice as well as being consistently perceived in public as a male, Sonya became withdrawn and depressed. She found herself being sexually turned off by his facial hair and new bodily smells, and most importantly, hated when they were viewed in public as heterosexual couple. Sonya felt confused about her own sexual orientation; she wondered if she could be involved with a trans-masculine partner, why not a cisgender man, and what did that mean for her sense of herself as a lesbian? On the other side, Lucas enjoyed his changing body; as he grew increasingly comfortable as a man, he wanted Sonya to embrace his changes. He felt rejected by her resistance to his transition and her unremitting identification as a lesbian.

For some lesbian-identified cisgender women (like Eleanor), negotiating sexuality across the gender binary is psychologically complicated. Adjusting to shifts in a partner's identity and

body may be easier for women who are pansexual or bisexual, in either identity or practice. Some lesbian-identified women do come to love, embrace, and value their partner's changing body, and they find it sexually desirable, although others struggle with this. Those who remain in relationships post-transition may still identify as lesbian or may begin to identify more as queer. In order to work therapeutically with Lucas and Sonya as a couple, it was important for their therapist to affirm their individual identities and also aid them in recognizing that while sexual orientation can feel immutable, sexual practices can be diverse and conceptually expansive.

Lucas and Sonya's therapist was able to bring a systemic awareness to the couple's work. Their therapist normalized for them that although sexual issues for TGNBQ people and their partners may be somewhat unique, coping with intimacy, honesty, communication, and changing bodies over time are universal concerns. The therapist comfortably modeled how they might effectively speak together about explicit, intimate sexual practices that were no longer working for them. Using curiosity, respectfulness, and authenticity, their therapist was able to effectively foster sexual communication that allowed them to explore together their varied experiences of gender and sexual identity and created a holding environment that successfully contained the anxiety caused by their changing identities, desires, and bodies, as well as the possibility of future sexual satisfaction.

In this case, it was essential for the therapist to seek out supervision to better understand the couple's history identifying as a butch-femme couple, so he could understand the erotic context of their sexuality. A thorough psychosocial sex assessment was provided to understand what sexual practices had been the most successful for both of them historically and what was currently different or changing. Which sexual acts or practices now felt less affirming for Lucas? Which practices were harder to experience together with Lucas living in a more masculine body and identity? The therapist created space for Sonya to talk honestly about male bodies, penises, and what it meant to be or identify as pansexual, bisexual, or heterosexual. Like Eleanor, there was much grieving for Sonya to do, because her identity as a lesbian represented more than just her sexual desire, but also her refusal to play a submissive role within her cultural community as a woman. Being a femme in a butch-femme dynamic gave her a fierce power that felt diminished by being perceived as the wife of a man. And she wondered how Lucas, now living and being identified as a Puerto Rican man, might see her differently as a cisgender male. Had that changed? Lucas was struggling with sexual practices that used to feel natural. For example, using a dildo now made him feel sad that he didn't have a "real penis." The thought of having the penis be real turned Sonya off and she hesitated to engage in oral sex with Lucas.

The therapist was able to model transparency and authenticity by asking direct questions, providing psychoeducation and encouraging them to create their own language to name their body parts and sexual practices. This couple was very honest and intimate with one another, which allowed bold and open discussions. At one point, Lucas was able to challenge the male-identified cisgender therapist about his privilege to discuss penises, as the therapist didn't have his own manhood threatened by not "having a real penis." When Sonya witnessed this pain, she was able to access her pride in Lucas's journey, and it made her more able to see his authenticity as a man. The therapist's ability to hold this conversation without shame, defensiveness, or hostility allowed this to be a transformative moment for the couple.

Conclusion

TGNBQ people represent a wide spectrum of individuals who express diverse sexual behavior and varied sexual relationships. For some TGNBQ people, gender dysphoria interferes with their sexual expression and comfort in their bodies; for others, living in complex gendered

bodies is experienced as sexually exciting and something to celebrate—even creating a feeling of gender *euphoria*. As is true for all individuals, there is a broad continuum of sexual behavior for TGNBQ people. Some are very conventional in their sexual behavior, whereas others appear more interested in diverse sexual practices. What sets TGNBQ people apart is that when they seek out sexual relationships with others, they have to navigate the socially constructed assumptions and biases related to their TGNBQ identities and embodiment.

Trans identities, by their very nature, cross the traditionally established sex binary, making it easy to assume that sexual relations between TGNBQ people and their sexual partners will also defy traditional expectations. However, it is often not the transition itself that is challenging for partners and families, but rather the immense discrimination and social stigma related to being TGNBQ in a cis-heteronormative culture. Despite these challenges, many TGNBQ people successfully navigate through the difficulties and maintain or create significant, ongoing, intimate relationships.

Clinicians must utilize newer models of assessment and treatment that respect the emerging paradigms of TGNBQ identity which are evolving and fluid and being developed in vivo by clients attempting to understand, practice, and live out their gender. It is at the junction where gender identity and sexual orientation meet that intimacy, desire, and sexuality take shape and new language is created to describe it. This can be as true of those cisgender individuals who fit neatly into the gender-sex binary as well as those who are TGNBQ. Effective sex therapy with TGNBQ people and their intimate partners will challenge clinicians to think differently about bodies and identities, including body modification and the complexity of sexual orientation. TGNBQ sex therapy can foster healthy sexual communication and can cultivate erotic desires within changing bodies.

References

Alessi, E. J. (2014). A framework for incorporating minority stress theory into treatment with sexual minority clients, *Journal of Gay & Lesbian Mental Health, 18*(1), 47–66. https://doi.org/10.1080/19359705.2013.789811

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). American Psychiatric Association.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Association. https://doi.org/10.1176/appi.books.9780890425596

Baral, S. D., Poteat, T., Strömdahl, S., Wirtz, A. L., Guadamuz, T. E., & Beyrer, C. (2013). Worldwide burden of HIV in transgender women: A systematic review and meta-analysis. *The Lancet: Infectious Diseases, 13*(3), 214–222. https://doi.org/10.1016/S1473-3099(12)70315-8

Basson, R. (2000). The female sexual response: A different model. *Journal of Sex & Marital Therapy, 26*(1), 51–65. https://doi.org/10.1080/009262300278641

Bauer, G. R., & Hammond, R. (2015). Toward a broader conceptualization of trans women and sexual health. *Canadian Journal of Human Sexuality, 24*(1), 1–11. https://doi.org/10.3138/cjhs.24.1-CO1

Bauer, G. R., Redman, N., Bradley, K., & Scheim, A. I. (2013). Sexual health of trans men who are gay, bisexual, or who have sex with men: Results from Ontario, Canada, *International Journal of Transgenderism, 14*(2), 66–74. https://doi.org/10.1080/15532739.2013.791650

Bauer, R. (2008). Transgressive and transformative gendered sexual practices and white privileges: The case of the dyke/trans BDSM communities. *Women's Studies Quarterly, 36*(3/4), 233–253. https://doi.org/10.1353/wsq.0.0100

Benjamin, H. (1966). *The transsexual phenomenon*. Julian Press.

Bettcher, T. M. (2014). When selves have sex: What the phenomenology of trans sexuality can teach about sexual orientation. *Journal of Homosexuality, 61*(5), 605–620. https://doi.org/10.1080/00918369.2014.865472

Bockting, W., Benner, A., & Coleman, E. (2009). Gay and bisexual identity development among female-to male transsexuals in North America: Emergence of a transgender sexuality. *Archives of Sexual Behavior, 38*(5), 688–701. https://doi.org/10.1007/s10508-009-9489-3

Boyd, H. (2003). *My husband Betty: Love, sex, and the life of a cross-dresser*. Thunder's Mouth Press.

Bränström, R., & Pachankis, J. E. (2019). Reduction in mental health treatment utilization among transgender individuals after gender-affirming surgeries: A total population study. *American Journal of Psychiatry, 117*(8), 727–734. https://doi.org/10.1176/appi.ajp.2019.19010080

Brown, N. (2010). The sexual relationships of sexual minority women partnered with trans men: A qualitative study. *Archives of Sexual Behavior, 39*(X), 561–572. https://doi.org/10.1007/s10508-009-9511-9

Callander, D., Wiggins, J., Rosenberg, S., Cornelisse, V. J., Duck-Chong, E., Holt, M., Pony, M., Vlahakis, E., MacGibbon, J., & Cook, T. (2019). *The 2018 Australian Trans and Gender Diverse Sexual Health Survey: Report of Findings*. The Kirby Institute, UNSW Sydney.

Clemmensen, L. H. (1990). The "real-life" test for surgical candidates. In R. Blanchard & B. W. Steiner (Eds.), *Clinical management of gender identity disorders in children and adults* (pp. 121–135). American Psychiatric Association.

Constantinides, D. M., Sennott, S. L., & Chandler, D. (2019). *Sex therapy with erotically marginalized clients: Nine principles of clinical support*. Routledge. https://doi.org/10.4324/9781315616780

Cromwell, J. (1999). *Transmen & FTMs: Identities, bodies, genders, and sexualities.* University of Illinois.

Currah, P. (2001). Queer theory, lesbian and gay rights, and transsexual marriages. In M. Biasius (Ed.), *Sexual identities—Queer politics* (pp. 178–197). Princeton University Press.

Daskalos, C. T. (1998). Changes in sexual orientation of six heterosexual male-to-female transsexuals. *Archives of Sexual Behavior, 27*(6), 605–613. https://doi.org/10.1023/A:1018725201811

De Cuypere, G., T'Sjoen, G., Beerten, R., Selvaggi, G., De Sutter, P., Hoebeke, P., Monstrey, S., Vansteenwegen, A., & Rubens, R. (2005). Sexual and physical health after sex reassignment surgery. *Archives of Sexual Behavior, 34*(6), 679–691. https://doi.org/10.1007/s10508-005-7926-5

Devor, A., & Dominic, K. (2015). Trans* sexualities. In J. DeLamate & R. Plante (Eds.), *Handbook of the sociology of sexualities* (pp. 181–199). Springer. https://doi.org/10.1007/978-3-319-17341-2_11

Devor, H. (1997). *FTM: Female-to-male transsexuals in society*. Indiana University Press.

Docter, R. F. (1988). *Transvestites and transsexuals: Toward a theory of cross-gender behavior*. Plenum Press. https://doi.org/10.1007/978-1-4613-0997-0

Dreger, A. (2000). *Hermaphrodites and the medical invention of sex.* Harvard University Press.

Edelman, E. A., & Zimman, L. (2014). Boycunts and bonus holes: Trans men's bodies, neoliberalism, and the sexual productivity of genitals. *Journal of Homosexuality, 61*(5), 673–690. https://doi.org/10.1080/00918369.2014.870438

Ekins, R., & King, D. (2007). *The transgender phenomenon*. Sage.

Erhardt, V. (2007). *Head over heels: Wives who stay with cross-dressers and transsexuals*. Haworth Press.

Ettner, R., & Brown, R. (1999). *Gender loving care: A guide to counseling gender-variant clients*. Norton.

Fernández-Rouco, N., Fernández-Fuertes, A. A., Carcedo, R. J., Lázaro-Visa, S., & Gómez- Pérez, E. (2017). Sexual violence history and welfare in transgender people. *Journal of Interpersonal Violence, 32*(19), 2885–2907. https://doi.org/10.1177/0886260516657911

Fleming, M., MacGowan, B., & Costos, D. (1985). The dyadic adjustment of female-to-male transsexuals. *Archives of Sexual Behavior, 14*(1), 47–55. https://doi.org/10.1007/BF01541352

Garofalo, R., Deleon, J., Osmer, E., Doll, M., & Harper, G. W. (2006). Overlooked, misunderstood and at-risk: Exploring the lives and HIV risk of ethnic minority male-to-female transgender youth. *Journal of Adolescent Health, 38*(3), 230–236. https://doi.org/10.1016/j.jadohealth.2005.03.023

Grant, J. M., Mottet, L. A., Tanis, J., Harrison, J., Herman, J. L., & Keisling, M. (2011). *Injustice at every turn: A report of the National Transgender Discrimination Survey.* National Center for Transgender Equality and National Gay and Lesbian Task Force.

Green, J. (2004). *Becoming a visible man*. Vanderbuilt Press.

Halberstam, J. (1998). *Female masculinity*. Duke Press. https://doi.org/10.2307/j.ctv11hpjb1

Hale, C. J. (1997). Leatherdyke boys and their daddies: How to have sex without women or men. *Social Text*, *52–53*(153/154), 223–236. https://doi.org/10.2307/466741

Hansbury, G. (2011). Trans/virtual: The anxieties of transsexual and electronic embodiments. *Journal of Gay & Lesbian Mental Health, 15*(3), 308–317. https://doi.org/10.1080/19359705.2011.581193

Hekma, G. (1994). A female soul in a male body: Sexual inversion as gender inversion in nineteenth-century sexology. In G. Herdt (Ed.), *Third sex third gender: Beyond sexual dimorphism in culture and history* (pp. 213–240). Zone Books.

Herbst, J. H., Jacobs, E. D., Finlayson, T. J., McKleroy, V. S., Neumann, M. S., & Crepaz, N. (2008). Estimating HIV prevalence and risk behaviors of transgender persons in the United States: A systematic review. *AIDS and Behavior, 12*(1), 1–17. https://doi.org/10.1007/s10461-007-9299-3

Hill-Meyer, T., & Scarborough, D. (2014). Sexuality. In L. Erickson-Schroth (Ed.), *Trans bodies, trans selves: A resource for the transgender community* (pp. 355–389). Oxford University Press

Holmberg, M., Arver, S., & Dhejne, C. (2019). Supporting sexuality and improving sexual function in transgender persons. *Nature Review Urology, 16,* 121–139. https://doi.org/10.1038/s41585-018-0108-8

Iantaffi, A., & Bockting, W. O. (2011). Views from both sides of the bridge? Gender, sexual legitimacy, and transgender people's experiences of relationships. *Culture, Health, and Sexuality, 13*(X), 355–370. https://doi.org/10.1080/13691058.2010.537770

Iasenza, S. (2010). What is queer about sex? Expanding sexual frames in theory and practice. *Family Process*, *49*(*2*), 291–308. https://doi.org/10.1111/j.1545-5300.2010.01324.x

Iasenza, S. (2020). *Transforming sexual narratives.* Routledge. https://doi.org/10.4324/9780429262371

James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M. (2016). *The Report of the 2015 U.S. Transgender Survey.* National Center for Transgender Equality.

Kane-Demaios, J. A., & Bullough, V. L. (Eds.). (2005). *Crossing sexual boundaries: Transgender journeys, uncharted paths*. Prometheus Books.

Kaplan, H. S. (1974). *New sex therapy: Active treatment of sexual dysfunctions*. Random House.

Kennedy, E. J., & Davis, M. D. (1993). *Boots of leather, slippers of gold: The history of a lesbian community.* Penguin Books.

Kleinplatz, P. J. (2001). A critique of the goals of sex therapy, or the hazards of safer sex. In P. J. Kleinplatz (Ed.), *New directions in sex therapy: Innovations and alternatives* (pp. 109–131). Brunner-Routledge.

Kleinplatz, P. J. (2012). Is that all there is? A new critique of the goals of sex therapy. In P. J. Kleinplatz (Ed.), *New directions in sex therapy: Innovations and alternatives* (2nd ed., pp. 101–118). Brunner-Routledge. https://doi.org/10.4324/9780203122556

Kockott, G., & Fahrner, E. -M. (1987). Transsexuals who have not undergone surgery: Follow-up study. *Archives of Sexual Behavior, 16*(6), 511–522. https://doi.org/10.1007/BF01541715

Kotula, D. (Ed.). (2002). *The phallus palace*. Alyson.

Koyama, E. (2003). The transfeminism manifesto. In R. Dicker & A. Piepmeier (Eds.), *Catching a wave: Reclaiming feminism for the 21st century* (pp. 244–262). Northeastern University Press.

Kuper, L. E., Nussbaum, R., & Mustanski, B. (2012). Exploring the diversity of gender and sexual orientation identities in an online sample of transgender individuals. *Journal of Sex Research, 49*(2–3), 244–254. https://doi.org/10.1080/00224499.2011.596954

Langer, S. J. (2016). Trans bodies and the failure of mirrors. *Studies in Gender and Sexuality, 17*(4), 306–316. https://doi.org/10.1080/15240657.2016.1236553

Lawrence, A. A. (2003). Factors associated with satisfaction or regret following male-to-female sex reassignment surgery. *Archives of Sexual Behavior, 32*(4), 299–315. https://doi.org/10.1023/A:1024086814364

Lev, A. I. (2004). *Transgender emergence: Counseling gender-variant people and their families*. Haworth Clinical Practice Press.

Lev, A. I. (2006). Transgender communities: Developing identity through connection. In K. Bieschke, R. Perez, & K. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients* (2nd ed., pp. 147–175). American Psychological Association. https://doi.org/10.1037/11482-006

Lev, A. I. (2008). More than surface tension: Femmes in families. *Journal of Lesbian Studies, 12*(2–3), 126–143. https://doi.org/10.1080/10894160802161299

Lev, A. I. (2013). Gender dysphoria: Two steps forward, one step back. *Clinical Social Work Journal, 41*(2), 288–296. https://doi.org/10.1007/s10615-013-0447-0

Lev, A. I. (2014). Understanding transgender identities and exploring sexuality and desire. In G. H. Allez (Ed.), *Sexual diversity and sexual offending: Research, assessment and clinical treatment in psychosexual therapy* (pp. 45–64). Karnac.

Lev, A. I., & Nichols, M. (2019). Sex therapy with same-sex couples. In K. M. Hertlein, N. Gambescia, & G. R. Weeks (Eds.), *Systemic sex therapy* (3rd ed., pp. 182–196). Routledge. https://doi.org/10.4324/9780429297403-12

Lev, A. I., & Sennott, S. (2012). Understanding gender nonconformity and transgender identity: A sex positive approach. In P. J. Kleinplatz (Ed.), *New directions in sex therapy: Innovations and alternatives* (pp. 321–336). Routledge.

Levitt, H. M., & Hiestand, K. R. (2005). Gender within lesbian sexuality: Butch and femme perspectives. *Journal of Constructivist Psychology, 18*(1), 39–51. https://doi.org/10.1080/10720530590523062

Lewins, F. (1995). *Transsexualism in society: A sociology of male-to-female transsexuals*. MacMillian Press.

Lombardi, E. L., Wilchins, R. A., Priesing, D., & Malouf, D. (2001). Gender violence: Transgender experiences with violence and discrimination. *Journal of Homosexuality*, *42*(1), 89–101. https://doi.org/10.1300/J082v42n01_05

Malpas, J. (2006). From otherness to alliance: Transgender couples in therapy. *Journal of GLBT Family Studies, 2*(3/4), 183–206. https://doi.org/10.1300/J461v02n03_10

Mason, M. E. (2006). *The experience of transition for lesbian partners of female-to-male transsexuals* [Unpublished doctoral dissertation]. Alliant International University, San Francisco.

Masters, W. H., & Johnson, V. E. (1966). *Human sexual response*. Bantam Books.

McCabe, M. P., Sharlip, I. D., Atalla, E., Balon, R., Fisher, A. D., Laumann, E., Lee, S. W., Lewis, R., & Segraves, R. T. (2016). Definitions of sexual dysfunctions in women and men: A consensus statement from the fourth international consultation on sexual medicine. *Journal of Sexual Medicine, 13*(X), 135–143. https://doi.org/10.1016/j.jsxm.2015.12.019

Meier, S. C., Pardo, S. T., Labuski, C., & Babcock, J. (2013). Measures of clinical health among female-to-male transgender persons as a function of sexual orientation. *Archives of Sexual Behavior, 42*(3), 463–74. https://doi.org/10.1007/s10508-012-0052-2

Meier, S. C., Sharp, C., Michonski, J., Babcock, J. C., & Fitzgerald, K. (2013). Romantic relationships of female-to-male trans men: A descriptive study. *International Journal of Transgenderism, 14*(2), 75–85. https://doi.org/10.1080/15532739.2013.791651

Monro, S. (2019). Non-binary and genderqueer: An overview of the field. *International Journal of Transgenderism, 20*(2–3), 126–131. https://doi.org/10.1080/15532739.2018.1538841

Namaste, V. K. (2000). *Invisible lives: The erasure of transsexual and transgendered people*. University of Chicago Press.

National Center for Transgender Equality (NCTE) & National Gay and Lesbian Task Force (NGLTF). (2009, November). *National transgender discrimination survey preliminary findings*. http://transequality.org/Resources/NCTE_prelim_survey_econ.pdf

Neider, T. O., Elaut, E., Richard, C. D., & Dekkera, A. (2016). Sexual orientation of trans adults is not linked to outcome of transition-related health care, but worth asking. *International Review of Psychiatry, 28*(1), 103–111. https://doi.org/10.3109/09540261.2015.1102127

Nestle, J., Wilchins, R., & Howell, C. (2002). *GenderQueer: Voices from beyond the sexual binary*. Alyson.

Nichols, M. (2000). Therapy with sexual minorities. In S. R. Leiblum & R. C. Rosen (Eds.), *Principles and practice of sex therapy* (4th ed., pp. 353–367). Guilford.

Nichols, M., & Shernoff, M. (2007). *Therapy with sexual minorities: Queering practice.* In S. R. Leiblum (Ed.), *Principles and practice of sex therapy* (p. 379–415). Guilford.

Nikkelen, S. W. C., & Kreukels, B. P. C. (2018). Sexual experiences in transgender people: The role of desire for gender-confirming interventions: Psychological well-being, and body satisfaction, *Journal of Sex & Marital Therapy, 44*(4), 370–381. https://doi.org/10.1080/0092623X.2017.1405303

Nuttbrock, L., Hwahng, S., Bockting, W., Rosenblum, A., Mason, M., Macri, M., & Becker, J. (2010). Psychiatric impact of gender-related abuse across the life course of male-to-female transgender persons. *Journal of Sex Research, 47*(1), 12–23. https://doi.org/10.1080/00224490903062258

Pfäfflin, F., & Junge, A. (1998). *Sex reassignment: Thirty years of international follow-up studies after sex reassignment surgery: A comprehensive review, 1961–1991.* International Journal of Transgenderism. http://web.archive.org/web/20061218132346/http://www.symposion.com/ijt/pfaefflin/1000.htm

Pope, K. S., Sonne, J. L., & Greene, B. G. (2006). *What therapists don't talk about and why: Understanding taboos that hurt us and our clients*. American Psychological Association. https://doi.org/10.1037/11413-000

Prosser, J. (1998). *Second skins: The body narratives of transsexuality*. Columbia University Press.

Rachlin, K. (1999). Factors which influence individual's decisions when considering female-to-male genital reconstructive surgery. *International Journal of Transgenderism, 3*(3).

Ramachandran, V. S., & McGeoch, P. D. (2008). Phantom penises in transsexuals: Evidence of an innate gender-specific body image in the brain. *Journal of Consciousness Studies, 15*(1), 5–16.

Rankin, S., & Beemyn, B. (2011). *The lives of transgender people*. Columbia University Press.

Reback, C. J., Kaplan, R. L., Bettcher, T. M., & Larkins, S. (2016). The role of the illusion in the construction of erotic desire: narratives from heterosexual men who have occasional sex with transgender women. *Culture, Health & Sexuality, 18*(8), 951–963. https://doi.org/10.1080/13691058.2016.1150515

Reisner, S. L., Whitea, J. M., Mayera, K. H. & Mimiagaa, M. J. (2014). Sexual risk behaviors and psychosocial health concerns of female-to-male transgender men screening for STDs at an urban community health center. *AIDS Care, 26*(7), 857–864. https://doi.org/10.1080/09540121.2013.855701

Richards, C., & Barker, M. (2013). *Sexuality and gender for mental health professionals: A practical guide*. Sage. https://doi.org/10.4135/9781473957817

Richards, C., Bouman, W. P., Seal, L., Barker, M. J., Nieder, T. O., & T'Sjoen, G. (2016). Nonbinary or genderqueer genders. *International Review of Psychiatry, 28*(1), 95–102. https://doi.org/10.3109/09540261.2015.1106446

Riggs, D. W., & Bartholomaeus, C. (2018). Transgender young people's narratives of intimacy and sexual health: Implications for sexuality education. *Sex Education*, *18*(4), 376–390. https://doi.org/10.1080/14681811.2017.1355299

Roen, K. (2002). "Either/0r" and "both/neither": Discursive tensions in transgender politics – TEST. *Signs, 27*(2), 501–522. https://doi.org/10.1086/495695

Ross, M. W., & Need, J. A. (1989). Effects of adequacy of gender reassignment surgery on psychological adjustment: A follow-up of fourteen male-to-female patients. *Archives of Sexual Behavior, 18*(2), 145–153. https://doi.org/10.1007/BF01543120

Rossman, K., Sinnard, M., & Budge, S. (2019). A qualitative examination of consideration and practice of consensual nonmonogamy among sexual and gender minority couples. *Psychology of Sexual Orientation and Gender Diversity, 6*(1), 11–21. https://doi.org/10.1037/sgd0000300

Rubin, G. (1984). Thinking sex: Notes for a radical theory of the politics of sexuality. In C. Vance (Ed.), *Pleasure and danger: Exploring female sexuality* (pp. 267–319). Routledge and Kegan Paul.

Samons, S. (2009). *When the opposite sex isn't: Sexual orientation in male-to-female transgender persons.* Routledge.

Schrock, D., Reid, L., & Boyd, E. (2005). Transsexuals' embodiment of womanhood. *Gender and Society, 19*(3), 317–335. https://doi.org/10.1177/0891243204273496

Schroder, M., & Carroll, R. (1999). New women: Sexological outcomes of male-to-female gender reassignment surgery. *Journal of Sex Education and Therapy, 24*(3), 137–146. https://doi.org/10.1080/01614576.1999.11074293

Schuylenbergh J. V., Motmans, J., & Coene, G. (2018). Transgender and non-binary persons and sexual risk: A critical review of 10 years of research from a feminist intersectional perspective. *Critical Social Policy, 38*(1), 121–142. https://doi.org/10.1177/0261018317732478

Sennott, S. (2011). Gender disorder as gender oppression: A transfeminist approach to rethinking the pathologization of gender non-conformity. *Women and Therapy, 34*(1/2), 93–113. https://doi.org/10.1080/02703149.2010.532683

Serano, J. (2007). *Whipping girl: A transsexual woman on sexism and the scapegoating of femininity*. Seal Press.

Sevelius, J. M. (2009). "There's no pamphlet for the kind of sex I have": HIV-related risk factors and protective behaviors among transgender men who have sex with nontransgender men. *Journal of the Association of Nurses in Aids Care, 20*(5), 398–410. https://doi.org/10.1016/j.jana.2009.06.001

Simon, W., & Gagnon, J. (1986). Sexual scripts: permanence and change. *Archives of Sexual Behavior, 15*(2), 97–120. https://doi.org/10.1007/BF01542219

Tiefer, L. (2001). Feminist critique of sex therapy: Foregrounding the politics of sex. In P. J. Kleinplatz (Ed.), *New directions in sex therapy: Innovations and alternatives* (pp. 29–49). Taylor & Francis.

Tiefer, L. (2012). The new view campaign: A feminist critique of sex therapy and an alternative vision. In P. J. Kleinplatz (Ed.), *New directions in sex therapy: Innovations and alternatives* (2nd ed., pp. 21–35). Routledge.

Tobin, H. J. (2003, April). *Sexuality in transsexual and transgender individuals.* Oberlin College. https://sites.google.com/site/hjtobin/Home/thesis-index

Tompkins, A. B. (2014). There's no chasing involved": Cis/trans relationships, "tranny chasers," and the future of a sex-positive trans politics. *Journal of Homosexuality, 61*(5), 766–780. https://doi.org/10.1080/00918369.2014.870448

Tully, B. (1992). *Accounting for transsexualism and transhomosexuality*. Whiting & Birch.

Valerio, M. W. (2006). *The testosterone files: My hormonal and social transformation from female to male*. Seal Press.

Vanderburgh, R. (2007). *Transition and beyond: Observations on gender identity*. Q Press.

Veale, J., Watson, R. J., Adjei, J., & Saewyc, E. (2016). Prevalence of pregnancy involvement among Canadian transgender youth and its relation to mental health, sexual health, and gender identity. *International Journal of Transgenderism, 17*(3–4), 107–113. https://doi.org/10.1080/15532739.2016.1216345

Viloria, H., & Nieto, M. (2020). *The spectrum of sex: The science of male, female, and intersex.* Jessica Kingsley Publishers.

Volcano, D. L., & Windh, I. (2005). GenderFusion. In I. Morland & A. Willox (Eds.), *Queer theory* (pp. 130–142). Palgrave/Macmillan. https://doi.org/10.1007/978-0-230-21162-9_11

von Krafft-Ebing, R. (2011). *Psychopathia sexualis: The classic study of deviant sex* (Reprint ed.). Skyhorse Publishing.

Wierckx, K., Elaut, E., Van Hoorde, B., Heylens, G., De Cuypere, G., Monstrey, S., Weyers, S., Hoebeke, P., & T'Sjoen, G. (2014). Sexual desire in trans persons: Associations with sex reassignment treatment. *Journal of Sexual Medicine, 11*(1), 107–118. https://doi.org/10.1111/jsm.12365

Williams, C. J., Weinberg, M. S., & Rosenberger, J. G. (2016). Trans women doing sex in San Francisco. *Archives of Sexual Behavior, 45*(7), 1665–1678. https://doi.org/10.1007/s10508-016-0730-6

Wirtz, A. L., Poteat, T. C., Malik, M., & Glass, N. (2018). Gender-based violence against Transgender people in the United States: A call for research and programming. *Trauma Violence Abuse, 21*(2), 227–241. https://doi.org/10.1177/1524838018757749

World Health Organization. (2019). *Sexual and reproductive health: Defining sexual health.* https://www.who.int/reproductivehealth/topics/sexual_health/sh_definitions/en/

11
Therapeutic Considerations in Same-Sex Divorce and Relationship Dissolution

KEVIN P. LYNESS

Introduction

While same-sex and sexual minority couples in long-term committed relationships have been breaking up for as long as there have been relationships, only recently have same-sex couples had the opportunity to legally marry, and thus divorce as a legal matter is now a consideration. This chapter starts by discussing the heteronormative context around legalizing marriage for same-sex couples, and then a case example is presented. Then, the chapter summarizes the recent legal landscape in the U.S., followed by a discussion of what is known about relationship dissolution in same-sex and sexual minority couples. Briefly discussed are risk and resiliency considerations. Finally, therapeutic considerations are discussed, focusing on how the literature on divorce therapy applies to same-sex and sexual minority couples.

It should be noted at the outset that there are those in the lesbian, gay, bisexual, and transgender community who believe that LGBTQ people should aspire to something more than what the format and structure of traditional marriages can offer (Card, 2007; Felicio & Sutherland, 2001; Rothblum, 2006). Card makes the case that marriage is so riddled with patriarchal injustices that it should not be the standard for durable relationships. Generally speaking, this means that power imbalances are expected and codified in marital relationships stemming from gendered notions of marriage and the roles of husband and wife. Practically speaking, these injustices include supporting differential access to healthcare and housing (those who are married have access that others do not have in the U.S.). Current divorce laws also do not typically allow for the unilateral termination of the marriage, trapping abused partners and those with less means. Card goes on to discuss the further complications of legal divorce:

> A dash of realism needed in the debate over same-sex marriage might be to think of it as the gay divorce issue, for part of the baggage of marriage is the liability to being divorced and the requirement of getting a divorce in order to signify similarly one's eternal commitment to a new partner. …Marriage and divorce can be such nightmares that I have difficulty wrapping my mind around the evident fact that so many same-sex couples in the United States have demonstrated their desire to marry by participating in public ceremonies.
>
> *(Card, 2007, p. 28)*

Heteronormativity

Marriage is based on heteronormativity and is therefore traditionally gendered and patriarchal (e.g. the roles of *husband* and *wife* are inherently gendered and unequal), creating a concern for how that patriarchy will be specifically enacted. This is uniquely true for sexual minority relationships since the imposition of patriarchal gender norms is also related to higher levels of homonegativity (Green & Mitchell, 2015). Partaking in something as traditionally

DOI: 10.4324/9780429274626-14

heteronormative as marriage can create a social expectation that people will behave in gender-normative (traditional) ways. When they do not engage in those behaviors as expected, there are social punishments and consequences (Weiler et al., 2015). Because of heteronormativity, there is fear that marriage will require heteronormative gender performance (Yep et al., 2019) and that divorce will further reinforce these roles. Homophobia and the associated stigma, discrimination, and violence create an atmosphere that can further stigmatize sexual minority couples who are divorcing by reinforcing cultural beliefs that these relationships are inherently less stable or wrong. While same-sex couples can now marry (weakening one of the heteronormative structures around marriage), gendered and heteronormative laws are still in place, including around custody, and the legal system still treats individuals differently based on gender (Kim & Stein, 2019).

One of the consequences of heteronormativity has been a valuing of patriarchal marriage which assumes that staying married is the definition of *stability*. Indeed, much of the literature on LGBTQ relationship dissolution uses a definition of stability based on formal or legal recognition of the relationship. Despite this, many marital relationships in the queer community challenge this notion of stability in the way they are conceived and constructed. The stigma that comes with divorce often intersects with homophobia and bias against queer people; an important stance for affirmative therapists will be to challenge these heteronormative assumptions in their work with same-sex and sexual minority couples.

The decision by the U.S. Supreme Court (Obergefell v. Hodges, 2015) that legalized same-sex marriage across the U.S. has had major implications for same-sex committed relationships (Gates & Brown; 2015; Goldberg & Romero, 2019; Hoy, 2018; Knauer, 2019; McCarthy, 2018; Ogolsky et al., 2019; Pew Research Center, 2019; Riggle et al., 2018; Romero, 2017). Goldberg and Romero's recent (2019) edited volume *LGBTQ Divorce and Relationship Dissolution* has many chapters detailing these effects and should be required reading for therapists and others working with same-sex and sexual minority couples divorcing or dissolving their long-term committed relationships. One implication is the reduction in stigma for LGBT relationships. Another important implication relates to the potential for protections for more disadvantaged partners and for clarity and protections related to child custody.

This chapter focuses particular attention on the therapeutic issues of those who have decided to marry and who are now contemplating divorce (or who face a similar legal dissolution of a civil union or domestic partnership). However, as noted below, many same-sex and other sexual minority couples have participated in religious marriage or commitment ceremonies that are not legally recognized, and many of the concepts in this chapter (particularly those that are non-legal) apply to these couples as well, even following *Obergefell*.

A Case Study

Derek and Gary are a married couple who live in a small town in western Massachusetts. Derek is a 45-year-old white cisgender male who works in advertising, while Gary is a 48-year-old African American cisgender male who works in a lower-paying field having experienced significant racial discrimination. Gary was raised in a conservative church and his family still holds very conservative beliefs about same-sex relationships. They had been together for many years prior to the legalization of gay marriage in their state and they were excited to take advantage of its benefits for their family. Massachusetts has long allowed adoptions by same-sex couples and Derek and Gary had adopted an infant boy in 2011. They believed that the legal recognition of marriage would help with Gary's family, who were strongly opposed to their relationship on religious grounds. This conflict with Gary's family was a long-standing source of stress for

the couple. Unfortunately, in the face of these kinds of social stressors as well as financial conflict and poor communication over the years, exacerbated by Derek's privilege and difficulty in understanding his partner's perspectives as a Black man, they had grown apart and have now presented to a couple therapist with the desire to end their relationship.

The therapy starts with a discussion of the recent emotional climate in the relationship. Both Gary and Derek report that in the past couple of years, they have trended toward more negative interactions and fewer positive ones. They report increased arguing over a number of issues, but particularly about money. The stress related to Gary's lack of family support has been an increasing source of conflict between the partners. They also report that their frequency of sex has decreased markedly. Neither partner reports any infidelity although before they married they had an open relationship for a while. They live in a welcoming community and do not experience much external homophobia, although they have faced more homophobia when they leave their community. They have experienced some racism as a mixed-race couple.

As part of the pre-divorce decision-making phase, the therapist works with the partners to make sure that this is not a knee-jerk reaction to conflict, though it is apparent from the history that this is not the case for this couple. One area that the therapist explores is where the couple plans to live after the divorce—both partners intend to stay in the state, making the legal context regarding parental rights easier to navigate.

It is important for the therapist to explore intersectional issues of power for this couple, both within the relationship and in society. Both have had to negotiate stigma and their own versions of internalized homophobia as gay men in a heteronormative culture. Derek earns more, is part of the majority racial/ethnic culture, and faces less hostility from family members about his sexuality. As a racialized minority, Gary has negotiated racism all of his life within society and within the gay community. He developed strong community and family ties within a conservative religious tradition that still sustain him as a Black man as they are simultaneously hostile to his identity as a gay man. Additionally, Gary is likely to experience a loss of socioeconomic status in the divorce and may also lose access to significant social supports. These multiple experiences of discrimination all affect his level of minority stress which will be important in helping this couple deal with conflict, equity, and co-parenting.

The partners present with significant conflict over parenting and custody. The therapist believes that mediation may be particularly helpful for this couple and refers them for several sessions of mediation with someone trained in working with same-sex couples. The mediation focuses on building effective co-parenting and establishing a joint custody plan. The therapist works to supplement the mediation by focusing the couple on developing some end-of-relationship rituals that will help to mark the transition for both them and their son. The therapist also helps them with family making—particularly Gary who cannot rely on his family for divorce support. The construct of *family making* comes from the work of Bella (as cited in Afifi & Hamrick, 2006). "Family making refers to the process that families engage in that helps them create, maintain, and strengthen the bonds that constitute their family" (p. 448). Family making involves acts of caring, creating intimacy, and sharing physical space, and even in divorce therapists can help families maintain bonds. Over several months, they work toward developing a solid co-parenting relationship, decreasing conflict between them, and setting appropriate boundaries. The therapist also helps them talk about ways to cope with stress related to discrimination and homophobia. When the divorce is final, the therapist recommends that both Derek and Gary each see someone individually to work on issues of loneliness and the stresses of co-parenting, as well as ongoing minority stress. In addition, they both intend to work on identity issues, trying to redefine themselves post-divorce.

Literature Review

Recent data show that the number of married same-sex couples has increased dramatically since *Obergefell*. Gates and Brown (2015) noted that in June of 2015 (when *Obergefell* was decided), there were approximately 390,000 married same-sex couples in the U.S., but by October of 2015 there were 486,000 married same-sex couples; Romero (2017) reported that by June of 2017 there were approximately 547,000 such couples. Similar to opposite-sex couples, not all same-sex couples in committed relationships choose to marry, and there are likely generational differences in this decision (Meyer & Krueger, 2019), and as noted above, decisions to marry for same-sex couples may be fraught with challenges regarding heteronormativity and politics as well (Lannutti, 2018; Lee-Attardo, 2018). Pfeffer and Castañeda (2019) explore many of these issues for trans partnerships and marriage.

As Yep et al. (2019) note: "Although there has been extensive coverage of same-sex marriage in U.S. mainstream and LGBT media, little attention has been paid, at this historical moment, to same-sex marriage's unspoken 'other'—that is, same-sex divorce" (p. 404). They attribute this to same-sex divorce being recent, that same-sex divorce may not be relevant to "unconventional long-term relationships" (p. 411), and to what they refer to as a "pseudo charmed circle that suppresses the visibility of same-sex divorce" (p. 411) which creates a hierarchy celebrating those who marry and marginalizing those who divorce or do not marry. There can be a great deal of shame in divorcing couples because they may see marriage as a civil rights celebration (Hertz, 2019). The silence around divorce is driven by shame, stigma, homophobia, and heteronormativity (Yep et al., 2019).

There are a number of same-sex and sexual minority couples who identify as married even though their marriage is not legally recognized (O'Connell & Lofquist, 2009). While legally these couples cannot divorce (although many legally recognized civil unions or domestic partnerships were converted to marriages following *Obergefell* and those couples will likely require legal action to dissolve their relationships), they may seek services of couple therapists substantively similar to divorce therapy. Sember (2006) also makes the point that even same-sex couples who are not legally married or in some other legally recognized relationship often have other legal entanglements (such as purchasing a house together and co-mingling finances), and these issues will have to be resolved.

Legal Context

As the legal status of same-sex marriage is greatly in flux around the world, the interested reader might consult online sources, such as Wikipedia https://en.wikipedia.org/wiki/Legal_status_of_same-sex_marriage, for the most up-to-date information. At the time of this writing, there are 28 countries that have legalized same-sex marriage, with one country where marriage is legal in parts of the country. There has been some recent research on same-sex relationship dissolution or divorce in countries, including Taiwan (Shieh, 2016) and Norway (Wiik et al., 2014). Dominguez et al. (2019) look at same-sex binational families in the U.S. and implications for citizenship. Knauer (2019) describes several difficulties in parenting rights and adoption, including challenges that non-biological parents have in gaining access to parenting rights.

There are several chapters in Goldberg and Romero (2019) detailing the current legal context in the U.S. Hertz (2019) explores the role of heteronormative marital law on same-sex divorce while Kim and Stein (2019) explore the role of gender and gender dynamics in same-sex relationship dissolution. Knauer (2019) delves into the implications of the *Obergefell* decision in an overview chapter. While the U.S. now enjoys equality of marriage rights, this has not yet been translated into equality regarding parenting rights (Knauer, 2019; Pearson, 2019), especially related to families with transgender individuals (Minter, 2019). One of the legacies of

homophobia in the U.S. is that many courts have operated under heterosexist myths in court proceedings (Kim & Stein; 2019; Knauer, 2019; Pearson, 2019). Much literature has been devoted to debunking these myths, especially regarding supposed negative outcomes for children (see Patterson, 2006, 2009). In study after study, children of gay and lesbian parents have been shown to be at least as well adjusted as children from opposite-sex relationships (Farr & Goldberg, 2019). Farr and Goldberg provide an up-to-date summary of the effects of both same-sex marriage and same-sex divorce on children. Generally speaking, children of same-sex parents divorcing are likely to experience similar outcomes to those with heterosexual divorcing parents. In the recent past, the lack of legal recognition of these relationships created additional stress, and these legal safeguards appear to matter. With regard to custody and the adoption of children, several states have recently passed laws restricting adoptions by gay men and lesbians. Following the *Obergefell* ruling, married same-sex couples qualify for joint adoption in all states but in many states the status of unmarried same-sex couples wishing to adopt is unclear (Knauer, 2019). As Knauer describes:

> Even if the parents are married and they are both listed on the birth certificate, a court order is necessary to ensure that both legal parents will be respected in all 50 states. This is because the Full Faith and Credit Clause of the U.S. Constitution requires states to respect court orders from sister states. A birth certificate does not constitute a court order, and it is not entitled to the Full Faith and Credit.
>
> *(p. 18)*

Understanding Relationship Dissolution in Same-Sex Couples

With the advent of marriage equality, there is a great deal more research on relationship dissolution in same-sex couples (Goldberg & Romero, 2019), including specific focus on predicting and understanding stability in same-sex relationships generally (Manning & Joyner, 2019; Rostosky & Riggle, 2019; Wahlig, 2017), in specific types of relationships, such as divorce when one parent comes out as LGB (Tasker & Rensten, 2019), and in partnerships with trans individuals (Minter, 2019; Pfeffer & Castañeda, 2019). The notion that stability is measured by an intact marriage can be seen as heteronormative, and many sexual minority couples may define success differently (i.e. not just as stability or intactness of the relationship but using less heteronormative criteria). As therapists work with couples going through relationship dissolution, guidance can be offered to the couple to help them define success on their terms for their relationship.

One of the most significant findings of an early study (Balsam et al., 2008) was the lack of difference in relationship dissolution rates for same-sex couples with civil unions and heterosexual married couples. Past research (Kurdek, 2004) had shown that same-sex relationships ended sooner than opposite-sex couples, and it now seems likely that legal contracts like civil unions and marriage are protective (Manning & Joyner, 2019; Rostosky & Riggle, 2019). Other recent work has confirmed this as well, with more formal relationships being more stable than cohabiting relationships, which were more stable than dating relationships (summarized by Manning & Joyner, 2019).

Another potential factor in same-sex relationship stability (and an important consideration in relationship dissolution) is parenthood (Rostosky & Riggle, 2019; Wiik et al., 2014). It is estimated that 114,000 same-sex couples were raising children together in 2016 (Goldberg & Conron, 2018), with about 75% of those being female same-sex couples. About 22% of same-sex married couples were raising children at that time (compared to about 12% of nonmarried same-sex couples). Interestingly, in male/female couples, there were virtually no differences between married and unmarried couples in the percentage raising children (38.6% and 38.7%). In addition, the majority of same-sex couples raising children (68%) were raising biological children of

one of the parents, and were much more likely than male/female couples to be raising adopted or foster children (Goldberg & Conron, 2018). In the case example, Derek and Gary are likely to experience stigma as gay fathers, exacerbated by their mixed-race relationship although they will experience this stigma and possible discrimination in different magnitudes—one as a Black gay man and one as a white gay man. These dynamics will carry over to their post-divorce relationship. As in couples therapy, having the couple explore areas of power and privilege and the consequences of these in current relationship can be helpful in addressing these issues (Weiler et al., 2015). In this case, an affirmative therapist can help Gary and Derek talk about how white privilege and racism will affect their entire family post-divorce. They will need guidance about how to recognize and address heteronormative and racist interpersonal dynamics. And in the best case scenario, they can learn to anticipate likely dilemmas and handle them together.

One study of children of lesbian couples who dissolved their relationships (Turteltaub, 2002) showed that they experienced many of the stresses of children of divorce in opposite-sex couples but also several stressors unique to having lesbian mothers. These additional stressors included having difficulty talking with others about their experience as others assumed that they had a mother and a father (sometimes, they lied about having two mothers and then felt bad "because they did not want people to think they were ashamed of their families"; Oswald & Clausell, 2006, p. 507). The children also reported feeling protective of their mothers, seeing them as vulnerable to prejudice. The children expressed appreciation for being raised in affirming households and this was a protective factor. One challenge, then, in same-sex divorce is protecting the children from the dual threats of divorce and perceived deviance of the family; this often falls to the parents to join forces in co-parenting, but this can be a great challenge for divorcing couples, as is true no matter the parent's sexual orientation (Gianino & Sackton, 2019; Morton, 1998). Children from lesbian families also have been noted to have additional financial hardships due to lower earning power of two female parents (see Farr & Goldberg, 2019 for a review) and may experience added stress due to homophobia and heteronormative assumptions that women will have husbands who support them.

There are real fears for LGBTQ people going through a divorce that they risk losing parental rights as one of the heteronormative assumptions in divorce is that both parents are biological and legal parents. One theme, then, is the fear of losing contact with their children due to a lack of legal parental rights (Allen, 2019; Chauveron et al., 2017; Dodge, 2006; Hertz et al., 2009; Kauffman, 2019; Knauer, 2019; Morton, 1998). The parent without legal standing is seriously disadvantaged from a power perspective, often feeling at the mercy of the biological or legal parent. While laws are changing, it is very likely that most couples with children now facing divorce or relationship dissolution will have experienced challenges with parenting rights laws. Park et al. (2016) describe how legal considerations shaped experiences of parenthood for same-sex couples, looking at both legal and social barriers.

For couple therapists working with same-sex couples considering divorce or other forms of relationship dissolution, it is likely that the reasons given for the divorce will be similar to those given by heterosexual couples, and therapists can use this awareness to reduce stigma. For example, Kurdek's research (1991—one of the earliest studies in this area) found that the most frequent reasons for ending same-sex relationships were nonresponsiveness and partner problems (such as drug or alcohol problems). More recent work has found similar themes in reasons for dissolution. For example, Balsam et al. (2017) looked at female same-sex partnerships and found two themes—relationship dissatisfaction and the effects of stressful life events. Other contributors to dissolution in Kurdek's research were frequent absence, sexual incompatibility, and mental cruelty, while Oswald and Clausell (2006) found that risks include financial issues like arguing about money, discrepant income levels, and not pooling finances. Balsam et al. (2017) identified risk factors such as shorter relationship length, younger age, and lower

relationship quality. For Gary and Derek, their financial conflict and decreasing relationship quality were significant factors in their decision to divorce.

Emotional responses to separation included personal growth, loneliness, and relief from conflict, while managing relationships with ex-partners and financial stress were the top problems experienced post-breakup (Kurdek, 1991). Managing well after the breakup was associated with higher education, less time in relationship with the ex-partner, maintaining independent finances, and lower reported levels of love and attachment to the partner. No differences were found between lesbian and gay male couples (Kurdek, 1991). Over time, couples whose relationship ended reported a decrease in positivity, an increase in relationship conflict, and an increase in personal autonomy. Importantly, most of these patterns held for opposite-sex as well as same-sex couples. Therapists should be asking partners about their particular emotional responses as they negotiate the divorce process, recognizing that there is a broad range of responses. Gary is particularly worried about his financial status after the divorce and the therapist is working with them both on communications skills, trying to reduce stonewalling, and on negative communication.

While many of the issues leading to relationship dissolution are very similar for same-sex and opposite-sex couples, there are some areas of unique stress in same-sex couples, primarily related to minority stress from heteronormativity and homophobia (Green, 2004; Green & Mitchell, 2002; Ritter & Terndrup, 2002). Current work is focusing on the effects of minority stress on same-sex couples (Frost & LeBlanc, 2019; Green & Mitchell, 2015), as well as negative effects of the current political climate (Gonzalez et al., 2018). These stigma-related processes can result in lower relational functioning, increased conflict between partners, and lower overall relationship satisfaction (Frost & LeBlanc, 2019). Frost and LeBlanc also present a helpful model of couple-level and dyadic minority stressors. Therapists working with divorcing couples should ask directly about each partner's experiences of discrimination (focusing on intersectionality) and stress. Of particular interest in therapy will be couples, like Derek and Gary, who have different levels of minority stress due to differential intersectional experiences of discrimination. If these stresses are not addressed overtly, post-divorce adjustment may be negatively affected.

Emotional Dynamics of Same-Sex Relationships Relevant to Divorce

Heteronormative gender role socialization may be both a strength and a challenge for sexual minority couples, and therapists working with these couples would be well-advised to assess and attend to how gender plays a part in the relationship dissolution and subsequent post-divorce adjustment. Several authors (Green, 2004; Greenan & Tunnell, 2002; Kim & Stein, 2019; Ossana, 2000; Ritter & Terndrup, 2002; Rostosky & Riggle, 2019) discuss how gender role socialization may provide challenges for same-sex couples (both in an ongoing relationship and in divorce). One issue is emotional fusion and avoidance of conflict in lesbian couples (see Green, 2004). However, in the context of patriarchal marriage, the evidence that fusion or female socialization creates problems in lesbian couples is complicated. As summarized by Ossana: "many of the relational features characterized as fusion…are related to the high levels of relationship satisfaction reported by lesbian couples. This level of emotional intimacy may encourage personal growth and risk taking by creating deeper trust and safety" (p. 281). Morton (1998) also talks about the construct of merger, or the high levels of emotional closeness in some lesbian relationships. According to Morton, merger may result in difficulties in tolerating difference after divorce or may make it difficult to differentiate after the divorce. However, in many lesbian communities, partners continue to remain close after relationship dissolution, and some authors have posited that the emotional closeness of lesbian relationships should not be pathologized but is instead a source of strength (Felicio & Sutherland, 2001; Matthews & Lease, 2000; Morton 1998). Similarly, for gay men, gender role socialization may lead to problems of emotional

disengagement or competition (Green, 2004). Male socialization typically rewards individuality and stoic behavior that may lead to intimacy challenges in gay male couples and may make post-divorce adjustment challenging as well, particularly in situations where co-parenting is necessary. Some research shows that relationship problems in gay male couples are linked to "an overdevelopment of skills and values associated with traditional masculinity" (Ossana, 2000, p. 279). One goal for therapy is to work with the partners to put aside these heteronormative assumptions about what their relationship should look like post-divorce and instead focus on their particular situation, strengths, and challenges.

One of the consequences of societal and political pressures is that there may be a perception that divorcing couples have to be especially careful to not have a "messy" divorce; that is, there is pressure to act in a way that does not further tarnish societal views of same-sex relationships (Morton, 1998). Several authors have also looked at how marriage equality has put additional pressures on couples around marriage and divorce (Balsam et al., 2017; Lannutti, 2018; Lee-Attardo, 2018; Yep et al., 2019). This is another opportunity for therapists to talk about gendered and heteronormative pressures on couples and should be directly addressed.

Therapeutic Considerations in Issues of Risk and Resiliency

Same-sex couples face unique minority stress issues, including event-based discrimination and stigma-related stress (Frost & LeBlanc, 2019). As Rostosky and Riggle (2019) describe it, "Unlike different-sex couples, same-sex couples form and maintain their relationships in a social context that stigmatizes their relationships for being nonheterosexual (or nonheteronormative)" (p. 58). Overall, stressors for all LGBT people include the deprivation of civil and legal rights as well as discrimination, bias, and violence, all of which are encountered in their families, workplaces, and communities. There is evidence that marriage equality is reducing some of this discrimination (Ogolsky et al., 2019; Riggle et al., 2017; Rostosky & Riggle, 2019) though by no means have these stresses been eliminated, and these stressors can affect the post-divorce adjustment of nonheterosexual couples. Kurdek (2006) notes that in both lesbian and gay cohabiting couples, partners report receiving more support from friends than from family, although Ogolsky and colleagues found that family support does seem to be increasing following marriage equality. Kurdek (2004, 2009) also reports that supports are important for relationship satisfaction in same-sex couples (as it is for opposite-sex couples), and is an important protective factor during relationship dissolution. Afifi and Hamrick (2006) note that social support in general, and family support specifically, is a protective factor in divorce among opposite-sex couples. It is likely that social supports play an even more important role in post-divorce adjustment for partners from same-sex relationships, given the hostile heterosexist nature of the overall culture. These social supports are often affected by homophobia and lack of acceptance, both in one's family of origin and in society at large (Frost & LeBlanc, 2019; Gartrell & Rothblum, 2019; Green, 2004; Green & Mitchell, 2002, 2015; Greene & Spivey, 2017; Oswald & Clausell, 2006; Riggle et al., 2018; Ritter & Terndrup, 2002; Rostosky & Riggle, 2019).

More recently, Green and Mitchell (2015) suggest interventions to counter minority stress experienced by same-sex couples that are applicable to divorcing couples, and Frost and LeBlanc (2019) discuss cognitive strategies "to frame the experience of minority stress as a social challenge that they can overcome" (p. 80) in post-divorce adjustment. Another resiliency strategy is to exercise what Frost and LeBlanc call "positive marginality" (p. 80), which involves defining for themselves nonheteronormative signposts of success in the relationship post-divorce. Gartrell and Rothblum (2019) describe seven strategies for same-sex couples navigating relationship challenges that also apply to building resilience in divorcing couples: acknowledging demographic and cultural differences, using community supports, perceiving and acknowledging differences in money and power, seeking therapy and legal advice, and compromising versus issuing an ultimatum.

Afifi and Hamrick (2006) identify the following risk factors for poor post-divorce adjustment in different-sex couples: (a) poor communication skills and negativity; (b) lack of flexibility and a certainty-orientation (i.e. being more comfortable when there is a great deal of clarity); (c) engaging in avoidant coping behaviors, parents' hostility and aggression toward one another (this is one of the strongest predictors of children's well-being in post-divorce opposite-sex families, particularly when children are caught in the middle of parental conflicts); and (d) poor conflict-management strategies (such as escalation, negativity, avoidance, and aggression). As Farr and Goldberg (2019) note, "Little research has examined children's response or adjustment to their same-sex parents' relationship dissolution, but available evidence indicates similarities to children who experience their heterosexual parents' divorce" (p. 158).

Afifi and Hamrick (2006) note that many of the challenges discussed above can then lead to difficulty with appropriate boundaries. The discussion of poor boundaries in post-divorce families involving children focuses on enmeshment and overreliance emotionally on the children and the negative effects this has on children (Afifi & Hamrick, 2006). As was noted earlier, children in same-sex divorce may feel even more pressure to protect their parents because of societal hostility creating additional loyalty binds. Research on the effects of this boundary ambiguity on children is somewhat equivocal. Some research contradicts the notion that emotional reliance on children is detrimental. For example, Arditti (1999) found, in qualitative interviews, that children experienced mothers' reliance on them positively and reported that they felt closer to their mothers. The majority of research from heterosexual divorce, however, does support the notion that role enmeshment can pose psychological risks for children (Afifi & Hamrick, 2006).

Afifi and Hamrick (2006) focus attention on the importance of effective co-parenting in post-divorce adjustment, as well as the negative effects of ongoing partner conflict. Clinicians can be aware of the loyalty conflicts that are often manifested in divorced families where there is a great deal of conflict—children are often forced to pick sides and they cannot maintain equitable relationships with both parents. While there is no research that explores whether this is exacerbated in divorce in same-sex couples, it may be that the additional legal confusion created by non-biological parents, second-parent adoptions (or the unavailability of such), and potential discrimination in the courts will have negative effects on children (and their parents) and should be carefully attended to by therapists working with divorcing same-sex families.

Finally, Afifi and Hamrick (2006) discuss the importance of family rituals in positive post-divorce adjustment. This may actually be a strength of divorcing same-sex partners in that since same-sex couples have in the past been denied legal marriage and the rituals associated with that, they have been free to develop their own sets of rituals marking relationship transitions, and many same-sex partner families have developed breaking-up rituals that may help to mark this transition for them and their families and friends (Felicio & Sutherland, 2001; Matthews & Lease, 2000). As noted earlier, active engagement in family making post-divorce has been found to help members reconstruct a sense of family after divorce (Afifi & Hamrick, 2006). Again, because gay and lesbian couples have had to actively engage in family making because they have been denied the traditional cultural family markers, they may have skills in this area that therapists and others can utilize. A focus on rituals in couple therapy with gay and lesbian families (both intact and divorcing) may be particularly important because gay and lesbian families are so often excluded from other rituals marking and resolving major life events (Ossana, 2000).

There are a number of factors that have been shown to be protective for children in opposite-sex divorce (Hetherington & Stanley-Hagan, 2000). These include personal characteristics of intelligence, an easy temperament, high academic achievement, self-worth, ego-strength, internal locus of control. In addition, a harmonious, supportive family environment with a residential parent who demonstrates high levels of warmth, responsiveness, control, and monitoring (i.e. an authoritative parenting style), as well as low conflict between co-parents, are all

important factors in promoting resiliency in these divorcing families. There is no reason to suspect that these factors would not also be important considerations in adjustment to same-sex divorce. Gianino and Sackton (2019) say: "[I]t is critical for clinicians to enhance protective factors through supporting co-parent adoption, encouraging positive extended family and communication connections, and urging members of the couple to sustain a civil relationship with their ex-partner" (pp. 265–266).

Intersectionality

The literature is starting to address issues of intersectionality in same-sex divorce. Frost and LeBlanc (2019) summarize the role of intersectionality in stress for divorcing same-sex couples, looking at race and SES. Both Farr and Goldberg (2019) and Pearson (2019) explore intersectionality in the lives of children and divorcing families with children. In each case, these authors look at how minority status (gender, race/ethnicity, immigration status, etc.) intersect with sexual orientation to exacerbate minority stress, looking at the unique stressors that fitting into multiple categories involves. Geography may also play a role (Frost & LeBlanc, 2019). For example, sexual minority couples in rural settings may face higher levels of stigma and discrimination, and this may be even more true for racial minority or mixed-race couples. These couples may also have different access to legal support services that are LGBT-friendly. Farr and Goldberg use an intersectional lens to look at the role of gender in parenting (with female same-sex couples more likely to have children and some evidence that female couples are more prone to relationship dissolution).

Another important example is in working with binational families where therapists are encouraged to become familiar with "anti-LGBTQ sentiments existing outside of the United States to understand the reasons many LGBTQ immigrants leave their home countries and pursue a new life in the United States" (Dominguez et al., 2019, p. 102). Complicating this is anti-immigrant and anti-LGBTQ sentiments in the U.S. It is important for therapists to work from an anti-oppression stance with awareness of intersectionality (Gianino & Sackton, 2019). An anti-oppression stance (Corneau & Stergiopoulos, 2018) is one that focuses on the role of power and that promotes egalitarianism and power sharing within the relationship (which becomes especially important when intersectionality creates differential power in the relationship and in society). An anti-oppression stance also challenges established norms that restrict access to power, such as heteronormativity and homophobia. In the case example with Gary and Derek, the therapist repeatedly brings issues of power into the room, both exploring the power dynamics within the couple relationship and how societal power has affected them as a couple, with a focus on how to combat those effects post-divorce. The therapist needs to ask questions about power and explore the power dynamics within the relationship and within society. Another likely place for this to come out in the case example is in the dynamics around child custody and parenting of a mixed-race child post-divorce. The therapist helped both parents think through how societal perceptions affect their notions about parenting. Both parents were also helped to think through ways to combat minority stress, including specific socialization strategies for their child, recognizing that the parent who feels more similar racially also feels greater pressure in this regard.

Additional Treatment and Intervention Considerations

General Considerations

It is important that therapists working with same-sex couples understand same-sex couple relationship dynamics—a full review of which is clearly beyond the scope of this chapter. I would direct the readers to several excellent sources on working with same-sex partners: Bigner and

Wetchler's (2004) *Relationship Therapy with Same-Sex Couples,* as well as the new edition of this volume (Bigner & Wetchler, 2012). Bieschke et al.'s (2007) *Handbook of Counseling and Psychotherapy with Lesbian, Gay, Bisexual, and Transgender Clients*, Greenan and Tunnell's (2002) *Couple Therapy with Gay Men*, Ritter and Terndrup's (2002), *Handbook of Affirmative Psychotherapy with Lesbians and Gay Men* as well as specific articles and chapters by Alonzo (2005), Green and Mitchell (2002, 2015), Greene and Spivey (2017), Long and Andrews (2007), Long and Lindsey (2004), and Wallace and Lyness (2004). Goldberg and Romero's (2019) book on LGBTQ divorce is an invaluable resource.

Applications from Divorce Therapy

Much of the initial work in divorce therapy was by Sprenkle (see *Divorce Therapy* by Sprenkle, 1985). Adams (2011), Emery and Sbarra (2002), Lebow (2015), Rice (2005), and Sprenkle and Gonzalez-Doupé (1996) have published chapters on divorce therapy or couple therapy with divorcing couples. None of these chapters has a focus on same-sex couples. The most helpful current resource on divorce therapy is Lebow's (2019) *Treating the Difficult Divorce*. Much of this clinical wisdom is useful for working with divorcing same-sex couples. As Lebow puts it:

> It perhaps goes without saying but is addressed here lest there be any question: Same-sex divorcing couples clearly deserve the same attention that opposite-sex (sic) couples do, whether or not they are regarded as married under state or national law. Readers should familiarize themselves with this literature on divorce therapy as there is only room to highlight some important considerations here. The best case is to treat these families as they do others, with the work informed by the special challenges LGBTQ families face.
>
> *(pp. 234–235)*

Divorce therapy "can be defined as relationship treatment that focuses on decreasing the function of the marital bond, with the eventual goal of dissolving it" (Sprenkle & Gonzalez-Doupé, 1996, p. 182), although the process itself is often not that clear-cut. Another way to think of this is that the goal is to change the nature of attachment the partners have with each other (Lebow, 2015). Many therapists utilize a stage model to conceptualize the divorce process, the most general of which involves three stages: (a) pre-divorce decision-making; (b) divorce restructuring; and (c) post-divorce recovery (Adams, 2011; Rice, 2005; Sprenkle & Gonzalez-Doupé, 1996), although all these authors note that this model is simply a heuristic and the process may not proceed linearly through the stages.

The decision-making phase may be the most important phase in working with same-sex couples. Considerations of the legal context may be particularly important here. Therapists working in this area should be well-informed of the legal contexts affecting the couple (Chauveron et al., 2017; Patterson, 2007; Pearson, 2019). The therapist will need to assess the clients' level of knowledge about the legal contexts described here in addition to more standard considerations of divorce therapy. Gary and Derek came to therapy firm in their decision to divorce. As noted earlier in the case example, the therapist asked them questions about where they plan to live in order to evaluate the complexity of custody and visitation.

The restructuring phase is often complicated and stressful, particularly for couples with children (Sprenkle & Gonzalez-Doupé, 1996). The confused legal context for same-sex couples will likely lead to fear, anxiety, and stress in divorcing couples beyond that experienced by heterosexual divorcing couples. The restructuring phase may be affected by the reasons for divorce, but perhaps in different ways than in opposite-sex couples. For example, infidelity is often a key reason for divorce in opposite-sex couples (Emery & Sbarra, 2002) but may not be an issue for may gay male couples (Greenan & Tunnell, 2002). This is where a thorough understanding

of same-sex couple dynamics is important, as it will help the therapist understand how these dynamics are affecting the divorce process. As noted earlier, infidelity was not an issue for Gary and Derek in their divorce, but the therapist was careful to ask about the history of their relationship.

Rice (2005) takes a developmental approach to divorce and focuses on issues of intimacy and identity, noting that dangers of divorce include a retreat from intimacy and/or commitment, and challenges to identity (e.g. identity diffusion due to defining oneself by one's relationship and incomplete self-differentiation). Also focused on identity, Morton (1998) notes that divorce for lesbians may also lead to challenges in minority sexual identity development. Therapists should be aware of their clients' level of minority sexual identity development, as well as their level of outness (which can vary between partners and may be an issue in divorce in a number of ways). Bernstein (2007) also focuses on family narratives in divorce therapy, particularly in challenging heteronormative ideas of the normal family. For Derek and Gary in the case example, both partners are out but Gary deals with higher levels of family-of-origin conflict. Both partners responded to questions about identity by noting that much of their identity is tied to marriage and parenthood, and they are both grieving the loss of that identity.

Gianino and Sackton (2019) lay out considerations for a clinical practice with separating and divorcing same-sex parent couples in the most comprehensive recent look at this topic. They suggest a process of establishing goals, determining whether parents can work together on parenting, structuring couple work with medium-conflict couples, and establishing a therapist orientation and position facilitative of progress. Their approach is summarized in this quote:

> Same-sex divorcing couples often benefit from therapy that is both queer-affirmative and skillfully helps parents de-escalate conflict as they sort out parenting plans and the details of parent communication, while protecting children from loyalty conflicts or from being go-betweens. The task of the clinician is to work with moderate-conflict couples to help them foster a post-divorce climate that provides children with a sense of coherence in their family life.
>
> *(p. 269)*

Lebow (2015, 2019) talks about establishing therapeutic alliance early; with sexual minority couples, the therapist needs to clearly communication an affirmative stance. In working with Gary and Derek, the therapist makes it clear that they support the couple's choices both to marry and to dissolve that relationship and highlights ways that minority stresses are likely affecting the couple and their conflict, in addition to more traditional communication skills training. Going beyond stating support, affirmative therapists help clients challenge heteronormative beliefs through deconstructing and subverting these external beliefs (Green & Mitchell, 2015). By tying their conflict to minority stress, the therapist helps Derek and Gary deconstruct the story behind some of their conflict and externalize the source. Both Derek and Gary will also benefit from connection with LGB community groups (Green & Mitchell, 2015), but especially Gary who lacks family support.

Veldorale-Griffen (2019) also highlights the need for a nonjudgmental and affirmative approach (including in work with trans parents divorcing). Lebow's (2019) book details specific interventions for higher conflict couples that would be appropriate as well. I would also direct readers to Argentino and Fiore's (2019) chapter on relationship dissolution in polyamorous, multiparent, and other complex families, especially as these families may be more stigmatized and disadvantaged, and may not have access to legal recourse upon relationship dissolution.

Mediation

One of the primary tools mentioned throughout the literature on same-sex divorce is mediation and consensual dispute resolution (Dodge, 2006; Felicio & Sutherland, 2001; Goodman & Geldenhuys, 2019; Hertz et al., 2009; Katz, 2007; Pearson, 2019). One of the key considerations in mediation, mentioned by each of these authors, is unbiased attention to internalized homophobia, as well as an understanding of the relationship dynamics of same-sex couples. Dodge (2006) makes several recommendations for mediation programs: (a) training for mediators on the varied familial constructs he or she might confront in same-sex married couples' families; (b) support for joint custody resolutions involving interaction between the two parents, but still respect the biological origins of the child; (c) if demonstrable, recognize the *de facto* parental role a same-sex partner had in raising the child; and (d) respect for pre-arrangement agreements.

Mediation is particularly important in cases where child custody is an issue (Dodge, 2006; Goodman & Geldenhuys, 2019; Hertz et al., 2009; Pearson, 2019). Traditionally, parentage has been established by giving birth (for women), being married to a woman who gave birth (for men), and by adoption. Contractual arrangements have not been deemed valid; for same-sex parents where egg and/or sperm donation or surrogacy have been used, challenges to the status quo have resulted. Legal parentage involves four factors: (a) biology and genetics; (b) procreative intent; (c) parental conduct; and (d) marital or domestic partnership or civil union, and nearly half of states recognize parentage based on parental conduct and bonding with the child (Hertz et al., 2009).

Disputes over parentage are more common in same-sex dissolutions than in opposite-sex dissolutions (Hertz et al., 2009) because of necessary reliance on adoption or assisted reproduction. These disputes typically arise in three instances: (a) where same-sex partners have functioned as parents but only one is a legal parent; (b) when a third party (sperm or egg donor, surrogate mother, involved family member) seeks parental rights; and (c) where a legal judgment has given both partners parental rights but one is now trying to disavow this arrangement or set aside an adoption. Mediation is likely to be the best way of addressing these disputes, particularly as partners can typically chose mediators who are LGB-friendly (Dodge, 2006; Goodman & Geldenhuys, 2019; Hertz et al., 2009; Pearson, 2019). Pearson provides an excellent summary of child custody issues in the context of LGBTQ divorce.

Recommendations for Future Research and Conclusions

Goldberg and Romero's edited volume (2019) summarizes the great strides that have been made in researching same-sex relationship dissolution and divorce, and nearly every chapter has recommendations for further research. In general, more research is needed that explores sexual orientation and gender identity across the range of constructs discussed here.

What research has been done has involved mostly white, educated, middle-class same-sex couples. More research is needed that explores how and why same-sex couples divorce, the unique dynamics associated with same-sex divorce and the effects of the legal context on these dynamics and divorce process, and on the utility and efficacy of divorce therapy with same-sex couples; all of this research needs to include diverse samples in diverse locations, and representing more diversity of ethnicity in couples is needed (such as the work of Blumer, 2008, who has studied gay men's experiences of couplehood in Alaska, and of Farmer, 2004, who studied gay Mexican-American men, as well as the more recent discussion by Dominguez et al., 2019, on binational families).

Another influence on same-sex relationship dissolution that needs addressing empirically is domestic violence (Oswald & Clausell, 2006). While Goldberg and Romero's (2019) book is quite comprehensive, it does not address any research on violence in same-sex relationships and the

association with relationship dissolution. See Chapter 19 (this volume) for a discussion on treatment issues with partner violence in LGBT relationships.

Same-sex divorce, from a legal perspective, is a new phenomenon in the U.S. The legal context is rapidly evolving, often confusing and contradictory, and saddled with heterosexist norms, beliefs, and laws that result in continued oppression and discrimination. While public acceptance of gay and lesbian committed relationships is clearly growing (Pew Research Center, 2019; Rothblum, 2006), there is still discrimination and oppression at many levels of society, and these affect couples in myriad ways. Therapists need to understand the changing legal context, their local legal context, and the contexts affecting the couple in question (Knauer, 2019; Patterson, 2007).

Therapists' beliefs and attitudes are extremely important for therapists working with same-sex couples (Alonzo, 2005; Bieschke et al., 2007; Emery & Sbarra, 2002; Gianino & Sackton, 2019; Green & Mitchell, 2002, 2015; Patterson, 2007; Veldorale-Griffen, 2019). When considering same-sex divorce, therapists must consider not only their attitudes and beliefs about gay and lesbian relationship but also their beliefs about separation and divorce (Emery & Sbarra, 2002; Gianino & Sackton, 2019; Rice, 2005). Therapists working to help same-sex couples with divorce or relationship dissolution must attend to not only the common experiences of all couples experiencing divorce but also the unique considerations of same-sex couples. When children are involved, complex legal issues related to custody must be attended to, while therapists must also attend to unique loyalty binds of children in these relationships as well as the social supports from community and families of origin. The issue of social support is complicated as well for divorcing couples who do not have children. Issues of gender role socialization are likely to be important. Finally, therapists working with same-sex couples must always be aware of heterosexist assumptions and of the potential for effects of oppression and discrimination, especially as these intersect with other identities linked to oppression. Therapists are well-advised to go beyond this introductory chapter and familiarize themselves with the literature on same-sex relationships and divorce therapy.

References

Adams, J. F. (2011). Divorce therapy. In J. L. Wetchler (Ed.), *Handbook of clinical issues in couple therapy* (2nd ed., pp. 165–187). Taylor & Francis.

Afifi, T. D., & Hamrick, K. (2006). Communication processes that promote risk and resiliency in postdivorce families. In M. A. Fine & J. H. Harvey (Eds.) *Handbook of divorce and relationship dissolution* (pp. 435–456). Lawrence Earlbaum.

Allen, K. R. (2019). Family, loss, and change: Navigating family breakup before the advent of legal marriage and divorce. In A. E. Goldberg & A. P. Romero (Eds.), *LGBTQ divorce and relationship dissolution: Psychological and legal perspectives and implications for practice* (pp. 221–232). Oxford University Press. https://doi.org/10.1093/med-psych/9780190635176.003.0012

Alonzo, D. J. (2005). Working with same-sex couples. In M. Harway (Ed.), *Handbook of couples therapy* (pp. 370–385). Wiley.

Arditti, J. A. (1999). Rethinking relationships between divorced mothers and their children: Capitalizing on family strengths. *Family Relations, 48*(2), 109–119. https://doi.org/10.2307/585074

Argentino, J. A., & Fiore, C. (2019). Dissolution of polyamorous relationships, multiple parent families, and other complex arrangements. In A. E. Goldberg & A. P. Romero (Eds.), *LGBTQ divorce and relationship dissolution: Psychological and legal perspectives and implications for practice* (pp. 422–440). Oxford University Press. https://doi.org/10.1093/med-psych/9780190635176.003.0023

Balsam, K. F., Beauchaine, T. P., Rothblum, E. D., & Solomon, S. E. (2008). Three-year follow-up of same-sex couples who had civil unions in Vermont, same-sex couples not in civil unions, and heterosexual married couples. *Developmental Psychology, 44*(1), 102–116. https://doi.org/10.1037/0012-1649.44.1.102

Balsam, K. F., Rostosky, S. S., & Riggle, E. D. B. (2017). Breaking up is hard to do: Women's experience of dissolving their same-sex relationship. *Journal of Lesbian Studies, 21*(1), 30–46. https://doi.org/10.1080/10894160.2016.1165561

Balsam, K. F., Rothblum, E. D., & Wickham, R. E. (2017). Longitudinal predictors of relationship dissolution among same-sex and heterosexual couples. *Couple and Family Psychology: Research and Practice, 6*(4), 247–257. https://doi.org/10.1037/cfp0000091

Bernstein, A. C. (2007). Re-visioning, restructuring, and reconciliation: Clinical practice with complex post-divorce families. *Family Process, 46*(1), 67–78. https://doi.org/10.1111/j.1545-5300.2006.00192.x

Bieschke, K. J., Perez, R., & DeBord, K. (Eds.). (2007). *Handbook of counseling and psychotherapy with lesbian, gay, bisexual, and transgender clients* (2nd ed.). American Psychological Association. https://doi.org/10.1037/11482-000

Bigner, J. J., & Wetchler, J. L. (Eds.). (2004). *Relationship therapy with same-sex couples*. Haworth.

Bigner, J. J., & Wetchler, J. L. (Eds). (2012). *Handbook of LGBT-affirmative couple and family therapy*. Taylor& Francis. https://doi.org/10.4324/9780203123614

Blumer, M. L. C. (2008). *Gay men's experiences of Alaskan society in their coupled relationships* [Unpublished doctoral dissertation]. Iowa State University.

Card, C. (2007). Gay divorce: Thoughts on the legal regulation of marriage. *Hypatia, 22*(1), 24–38. https://doi.org/10.1111/j.1527-2001.2007.tb01147.x

Chauveron, L. M., Alvarez, A., & van Eeden-Moorefield, B. (2017). The co-evolution of marriage and parental rights of gays and lesbians. *Journal of GLBT Family Studies, 13*(2), 114–136. https://doi.org/10.1080/1550428X.2016.1187105

Corneau, S., & Stergiopoulos, V. (2018). More than being against it: Anti-racism and anti-oppression in mental health services. *Transcultural Psychiatry, 49*(2), 261–282. https://doi.org/10.1177/1363461512441594

Dodge, J. A. (2006). Same-sex marriage and divorce: A proposal for child custody mediation. *Family Court Review, 44*(1), 87–103. https://doi.org/10.1111/j.1744-1617.2006.00069.x

Dominguez, D. G., Coppock, J., & polanco, m. (2019). Same-sex binational families: Risk factors for relationship dissatisfaction, conflict, and divorce. In A. E. Goldberg & A. P. Romero (Eds.), *LGBTQ divorce and relationship dissolution: Psychological and legal perspectives and implications for practice* (pp. 87–108). Oxford University Press. https://doi.org/10.1093/med-psych/9780190635176.003.0006

Emery, R. E., & Sbarra, D. A. (2002). Addressing separation and divorce during and after couple therapy. In A. S. Gurman & N. S. Jacobson (Eds.), *Clinical handbook of couple therapy* (3rd ed., pp. 508–530). Guilford.

Farmer, S. (2004). *A phenomenological study of gay, Mexican-American men who disclose their HIV+ status to their family* [Unpublished doctoral dissertation]. St. Mary's University.

Farr, R. H., & Goldberg, A. E. (2019). Same-sex relationship dissolution and divorce: How will children be affected? In A. E. Goldberg & A. P. Romero (Eds.), *LGBTQ divorce and relationship dissolution: Psychological and legal perspectives and implications for practice* (pp. 151–172). Oxford University Press. https://doi.org/10.1093/med-psych/9780190635176.003.0009

Felicio, D., & Sutherland, M. (2001). Beyond the dominant narrative: Intimacy and conflict in lesbian relationships. *Mediation Quarterly, 18*(4), 363–376. https://doi.org/10.1002/crq.3890180405

Frost, D. M., & LeBlanc, A. J. (2019). Stress in the lives of same-sex couples: Implications for relationship dissolution and divorce. In A. E. Goldberg & A. P. Romero (Eds.), *LGBTQ divorce and relationship dissolution: Psychological and legal perspectives and implications for practice* (pp. 70–86). Oxford University Press. https://doi.org/10.1093/med-psych/9780190635176.003.0005

Gartrell, N. K., & Rothblum, E. D. (2019). Conclusion: Conversations with long-term couples who have faced challenges and navigated through them. In A. E. Goldberg & A. P. Romero (Eds.), *LGBTQ divorce and relationship dissolution: Psychological and legal perspectives and implications for practice* (pp. 441–458). Oxford University Press. https://doi.org/10.1093/med-psych/9780190635176.003.0024

Gates, G. J., & Brown, T. N. T. (2015). *Marriage and same sex couples after* Obergefell. The Williams Institute.

Gianino, M., & Sackton, E. (2019). From conflict to co-parenting: Considerations in clinical practice with separating and divorcing same-sex parent couples. In A. E. Goldberg & A. P. Romero (Eds.), *LGBTQ divorce and relationship dissolution: Psychological and legal perspectives and implications for practice* (pp. 263–284). Oxford University Press. https://doi.org/10.1093/med-psych/9780190635176.003.0015

Goldberg, A. E., & Romero, A. P. (Eds.). (2019). *LGBTQ divorce and relationship dissolution: Psychological and legal perspectives and implications for practice*. Oxford University Press. https://doi.org/10.1093/med-psych/9780190635176.001.0001

Goldberg, S. K., & Conron, K. J. (2018). *How many same-sex couples in the US are raising children?* The Williams Institute.

Gonzalez, K. A., Ramirez, J. L., & Galupo, M. P. (2018). Increase in GLBTQ minority stress following the 2016 US presidential election. *Journal of GLBT Family Studies, 14*(1–2), 130–151. https://doi.org/10.1080/1550428X.2017.1420849

Goodman, D. M., & Geldenhuys, M. (2019). Consensual dispute resolution with same-sex couples. In A. E. Goldberg & A. P. Romero (Eds.) *LGBTQ divorce and relationship dissolution: Psychological and legal perspectives and implications for practice* (pp. 133–146). Oxford University Press. https://doi.org/10.1093/med-psych/9780190635176.003.0008

Green, R. -J. (2004). Forward. In J. J. Bigner & J. L. Wetchler (Eds.), *Relationship therapy with same-sex couples* (pp. xiii–xvii). Haworth.

Green, R. -J., & Mitchell, V. (2002). Gay and lesbian couples in therapy: Homophobia, relational ambiguity, and social support. In A. S. Gurman & N. Jacobson (Eds.), *Clinical handbook of couple therapy* (3rd ed., pp. 546–568). Guilford.

Green, R. -J., & Mitchell, V. (2015). Gay, lesbian, and bisexual issues in couple therapy. In A. S. Gurman, J. L. Lebow, & D. K. Snyder (Eds.), *Clinical handbook of couple therapy* (5th ed., pp. 489–511). Guilford Press.

Greenan, D., & Tunnell, G. (2002). *Couple therapy with gay men*. Guilford.

Greene, B., & Spivey, P. B. (2017). Sexual minority couples and families: Clinical considerations. In S. Kelly (Ed.) *Diversity in couple and family therapy: Ethnicities, sexualities, and socioeconomics* (pp. 181–199). Praeger.

Hertz, F. (2019). Emerging legal issues in same-sex divorces: A lawyer's view of the unanticipated effects of heteronormative marital law. In A. E. Goldberg & A. P. Romero (Eds.), *LGBTQ divorce and relationship dissolution: Psychological and legal perspectives and implications for practice* (pp. 383–401). Oxford University Press. https://doi.org/10.1093/med-psych/9780190635176.003.0021

Hertz, F., Wald, D., & Shuster, S. (2009). Integrated approaches to resolving same-sex dissolutions. *Conflict Resolution Quarterly, 27*(2), 123–143. https://doi.org/10.1002/crq.252

Hetherington, E., & Stanley-Hagan, M. (2000). Divorce. In A. Kazdin (Ed.), *The encyclopedia of psychology* (Vol. 3, pp. 61–65). American Psychological Association. https://doi.org/10.1037/10518-019

Hoy, A. (2018). Invisibility, illegibility, and stigma: The citizenship experiences of divorced gays and lesbians. *Journal of Divorce & Remarriage, 59*(2), 69–91. https://doi.org/10.1080/10502556.2017.1375332

Katz, E. (2007). A family therapy perspective on mediation. *Family Process, 46*(1), 93–107. https://doi.org/10.1111/j.1545-5300.2006.00194.x

Kauffman, J. (2019). A lesbian parent's perspective on LGBTQ families of choice: Sharing custody when there is no legal requirement to do so. In A. E. Goldberg & A. P. Romero (Eds.), *LGBTQ divorce and relationship dissolution: Psychological and legal perspectives and implications for practice* (pp. 233–244). Oxford University Press. https://doi.org/10.1093/med-psych/9780190635176.003.0013

Kim, S. A., & Stein, E. (2019). The role of gender and gender dynamics in same-sex divorce and dissolution. In A. E. Goldberg & A. P. Romero (Eds.), *LGBTQ divorce and relationship dissolution: Psychological and legal perspectives and implications for practice* (pp. 353–382). Oxford University Press. https://doi.org/10.1093/med-psych/9780190635176.003.0020

Knauer, N. J. (2019). Implications of *Obergefell* for same-sex marriage, divorce, and parental rights. In A. E. Goldberg & A. P. Romero (Eds.), *LGBTQ divorce and relationship dissolution: Psychological and legal perspectives and implications for practice* (pp. 7–30). Oxford University Press. https://doi.org/10.1093/med-psych/9780190635176.003.0002

Kurdek, L. A. (1991). The dissolution of gay and lesbian couples. *Personal Relationships, 8*(2), 265–278. https://doi.org/10.1177/0265407591082006

Kurdek, L. A. (2004). Are gay and lesbian cohabiting couples *really* different from heterosexual married couples? *Journal of Marriage and Family, 66*(4), 880–900. https://doi.org/10.1111/j.0022-2445.2004.00060.x

Kurdek, L. A. (2006). Differences between partners from heterosexual, gay, and lesbian cohabiting couples. *Journal of Marriage and Family, 68*(2), 509–528. https://doi.org/10.1111/j.1741-3737.2006.00268.x

Kurdek, L. A. (2009). Assessing the health of a dyadic relationship in heterosexual and same-sex partners. *Personal Relationships, 16*(1), 117–127. https://doi.org/10.1111/j.1475-6811.2009.01213.x

Lannutti, P. J. (2018). GLBTQ people who decided to marry after the 2016 U.S. election: Reasons for and meanings of marriage. *Journal of GLBT Family Studies, 14*(1–2), 85–100. https://doi.org/10.1080/1550428X.2017.1420846

Lebow, J. L. (2015). Separation and divorce issues in couple therapy. In A. S. Gurman, J. L. Lebow, & D. K. Snyder (Eds.), *Clinical handbook of couple therapy* (5th ed., pp. 445–466). Guilford.

Lebow, J. L. (2019). *Treating the difficult divorce: A practical guide for psychotherapists*. American Psychological Association. https://doi.org/10.1037/0000116-000

Lee-Attardo, A. L. (2018). *Minority stress, same-sex couples, and marriage equality: A qualitative interview study* [Unpublished doctoral dissertation]. Antioch University New England.

Long, J. K., & Andrews, B. V. (2007). Fostering strength and resiliency in same-sex couples: An overview. *Journal of Couple and Relationship Therapy, 6*(1/2), 153–165. https://doi.org/10.1300/J398v06n01_13

Long, J. K., & Lindsey, E. (2004). The sexual orientation matrix for supervision: A tool for training therapists to work with same-sex couples. In J. J. Bigner & J. L. Wetchler (Eds.), *Relationship therapy with same-sex couples* (pp. 123–135). Haworth. https://doi.org/10.1300/J398v03n02_12

Manning, W. D., & Joyner, K. (2019). Demographic approaches to same-sex relationship dissolution and divorce: Research findings, data challenges, and implications for future research. In A. E. Goldberg & A. P. Romero (Eds.), *LGBTQ divorce and relationship dissolution: Psychological and legal perspectives and implications for practice* (pp. 35–48). Oxford University Press. https://doi.org/10.1093/med-psych/9780190635176.003.0003

Matthews, C. R., & Lease, S. H. (2000). Focus on lesbian, gay, and bisexual families. In R. M. Perez, K. A. DeBord, & K. J. Bieschke (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients* (pp. 249–273). American Psychological Association. https://doi.org/10.1037/10339-011

McCarthy, J. (2018). *Two in three Americans support same-sex marriage*. Gallup World Headquarters. https://news.gallup.com/poll/234866/two-three-americans-support-sex-marriage.aspx

Meyer, I. H., & Krueger, E. A. (2019). *Legally married LGB people in the United States*. The Williams Institute.

Minter, S. P. (2019). Legal issues in divorce for transgender individuals. In A. E. Goldberg & A. P. Romero (Eds.), *LGBTQ divorce and relationship dissolution: Psychological and legal perspectives and implications for practice* (pp. 312–326). Oxford University Press. https://doi.org/10.1093/med-psych/9780190635176.003.0017

Morton, S. B. (1998). Lesbian divorce. *American Journal of Orthopsychiatry, 68*(3), 410–419. https://doi.org/10.1037/h0080350

Obergefell v. Hodges, 135 S. Ct. 2584 (2015).

O'Connell, M., & Lofquist, D. (2009). *Counting same-sex couples: Official estimates and unofficial guesses* [Paper presentation]. Annual Meeting of the Population Association of America, Detroit, MI, United States.

Ogolsky, B. G., Monk, J. K., Rice, T. M., & Oswald, R. F. (2019). Personal well-being across the transition to marriage equality: A longitudinal analysis. *Journal of Family Psychology, 33*(4), 422–432. https://doi.org/10.1037/fam0000504

Ossana, S. M. (2000). Relationship and couples counseling. In R. M. Perez, K. A. DeBord, & K. J. Bieschke (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients* (pp. 275–302). American Psychological Association. https://doi.org/10.1037/10339-012

Oswald, R. F., & Clausell, E. (2006). Same-sex relationships and their dissolution. In M. A. Fine, & J. H. Harvey (Eds.), *Handbook of divorce and relationship dissolution* (pp. 499–514). Lawrence Earlbaum.

Park, N. K., Kazyak, E., & Slauson-Blevins, K. (2016). How law shapes experiences of parenthood for same-sex couples. *Journal of GLBT Family Studies, 12*(2), 115–137. https://doi.org/10.1080/1550428X.2015.1011818

Patterson, C. J. (2006). Children of lesbian and gay parents. *Current Directions in Psychological Science, 15*(5), 241–244. https://doi.org/10.1111/j.1467-8721.2006.00444.x

Patterson, C. J. (2007). Lesbian and gay family issues in the context of changing legal and social policy environments. In K. Bieschke, R. Perez, & K. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, bisexual, and transgender clients* (2nd ed., pp. 359–377). American Psychological Association. https://doi.org/10.1037/11482-015

Patterson, C. J. (2009). Children of lesbian and gay parents: Psychology, law, and policy. *American Psychologist, 64*(8), 727–736. https://doi.org/10.1037/0003-066X.64.8.727

Pearson, K. H. (2019). Child custody in the context of LGBTQ relationship dissolution and divorce. In A. E. Goldberg & A. P. Romero (Eds.), *LGBTQ divorce and relationship dissolution: Psychological and legal perspectives and implications for practice* (pp. 195–220). Oxford University Press. https://doi.org/10.1093/med-psych/9780190635176.003.0011

Pew Research Center. (2019). *Majority of public favors same-sex marriage, but divisions persist*. www.pewresearch.org

Pfeffer, C. A., & Castañeda, N. N. (2019). Trans partnership and marriage: Risk factors for conflict, dissolution, and divorce. In A. E. Goldberg & A. P. Romero (Eds.), *LGBTQ divorce and relationship dissolution: Psychological and legal perspectives and implications for practice* (pp. 287–311). Oxford University Press. https://doi.org/10.1093/med-psych/9780190635176.003.0016

Rice, J. K. (2005). Divorcing couples. In M. Harway (Ed.), *Handbook of couples therapy* (pp. 405–430). Wiley.

Riggle, E. D. B., Drabble, L., Veldhuis, C. B., Wootton, A., & Hughes, T. L. (2018). The impact of marriage equality on sexual minority women's relationships with their families of origin. *Journal of Homosexuality, 65*(9), 1190–1206. https://doi.org/10.1080/00918369.2017.1407611

Riggle, E. D. B., Wickham, R. E., Rostosky, S. S., Rothblum, E. D., & Balsam, K. F. (2017). Impact of civil marriage recognition for long-term same-sex couples. *Sexuality Research and Social Policy, 14*(2), 223–232. https://doi.org/10.1007/s13178-016-0243-z

Ritter, K., & Terndrup, A. (2002). *Handbook of affirmative psychotherapy with lesbians and gay men*. Guilford.

Romero, A. P. (2017). *1.1 million LGBT adults are married to someone of the same sex at the two-year Anniversary of* Obergefell v. Hodges. The Williams Institute.

Rostosky, S. S., & Riggle, E. D. B. (2019). What makes same-sex relationships endure? In A. E. Goldberg & A. P. Romero (Eds.), *LGBTQ divorce and relationship dissolution: Psychological and legal perspectives and implications for practice* (pp. 49–69). Oxford University Press. https://doi.org/10.1093/med-psych/9780190635176.003.0004

Rothblum, E. D. (2006). Same-sex marriage and legalized relationships: I do, or do I? In J. J. Bigner (Ed.), *An introduction to GLBT family studies* (pp. 203–214). Haworth.

Sember, B. M. (2006). *The complete gay divorce*. Career Press.

Shieh, W. (2016). Why same-sex couples break up: A follow-up study in Taiwan. *Journal of GLBT Family Studies, 12*(3), 257–276. https://doi.org/10.1080/1550428X.2015.1057887

Sprenkle, D. H. (1985). *Divorce therapy*. Haworth.

Sprenkle, D. H., & Gonzalez-Doupé, P. (1996). Divorce therapy. In F. P. Piercy, D. H. Sprenkle, J. L. Wetchler & Associates (Eds.), *Family therapy sourcebook* (2nd ed., pp. 181–219). Guilford.

Tasker, F., & Rensten, K. (2019). Social science research on heterosexual relationship dissolution and divorce where one parent comes out as LGB. In A. E. Goldberg & A. P. Romero (Eds.), *LGBTQ divorce and relationship dissolution: Psychological and legal perspectives and implications for practice* (pp. 173–194). Oxford University Press. https://doi.org/10.1093/med-psych/9780190635176.003.0010

Turteltaub, G. L. (2002). The effects of long-term primary relationship dissolution on the children of lesbian parents. *Dissertation Abstracts International: Section B: The Sciences and Engineering, 63*(5-B), 2610.

Veldorale-Griffen, A. (2019). A daughter of a transgender parent's perspective on relationship dissolution. In A. E. Goldberg & A. P. Romero (Eds.), *LGBTQ divorce and relationship dissolution: Psychological and legal perspectives and implications for practice* (pp. 340–348). Oxford University Press. https://doi.org/10.1093/med-psych/9780190635176.003.0019

Wahlig, J. L. (2017). *Journey to success: Lessons from successful same-sex couples* [Unpublished doctoral dissertation]. Antioch University New England.

Wallace, D., & Lyness, K. P. (2004). Resources on same-sex couples for therapists and clients. In J. J. Bigner & J. L. Wetchler (Eds.), *Relationship therapy with same-sex couples* (pp. 147–155). Haworth. https://doi.org/10.1300/J398v03n02_14

Weiler, L. M., Lyness, K. P., Haddock, S. A., & Zimmerman, T. S. (2015). Contextual issues in couple and family therapy: Gender, sexual orientation, culture, and spirituality. In L. Hecker & J. Wetchler (Eds.), *An introduction to marriage and family therapy* (2nd ed., pp. 65–116). Routledge.

Wiik, K. A., Seierstad, A., & Noack, T. (2014). Divorce in Norwegian same-sex marriages and registered partnerships: The role of children. *Journal of Marriage and Family, 76*(5), 919–929. https://doi.org/10.1111/jomf.12132

Yep, G. A., Gigi, R. N., & Avila, B. E. (2019). Exploring the polysemy of voice and silence: (Not) talking about divorce after the US legalization of same-sex marriage. In A. E. Goldberg & A. P. Romero (Eds.), *LGBTQ divorce and relationship dissolution: Psychological and legal perspectives and implications for practice* (pp. 402–421). Oxford University Press. https://doi.org/10.1093/med-psych/9780190635176.003.0022

Section III
Family and Identity Considerations

Taylor & Francis
Taylor & Francis Group
http://taylorandfrancis.com

12
Invisible Humans
Identity Development and Visibility Management in Gender, Sexual, Erotic, and Relational Diversity

MARKIE LOUISE CHRISTENSON (L. C.) TWIST,[1] RAVEN CLOUD and SARAH A. HECHTER

Gender, sexual, erotic, and relational diversity (GSERD) is an emerging umbrella term aimed at more comprehensively recognizing the diversity of sexuality and gender within people than is captured by common Westernized conceptualizations which tend to dominate (i.e. lesbian, gay, bisexual, and transgender +; LGBT+; Davies & Barker, 2015; Twist, 2016a, 2018, 2019). The theoretical conceptualization of GSERD includes the diversity within and between humans around gender (cisgender, transgender, agender), sexuality (heterosexual, gay, lesbian, asexual, bisexual, pansexual), eroticism (kinky, fetishists, non-kinky), and relationality (monogamous, monogamish, polyamorous).

How many people comprise the GSERD communities? According to findings from a 2017 Gallup poll, 4.5% of adults in the U.S. identify as LGBT (Newport, 2018). The Williams Institute has shown that an estimated 1.4 million people identify as transgender, which accounts for 0.6% of the adult population (Flores et al., 2016). In addition, researchers found that about 4–5% of the adult population in the U.S. are currently in a consensually non-monogamous relationship/s (CNM; Rubin et al., 2014), and a like percentage has been found in the adult population of Canada (Fairbrother et al., 2019). Finally, according to an analysis reported in a 1990 Kinsey Institute Report, between 5 and 10% of the adult population in the U.S. engage in sadomasochism (SM) for sexual pleasure, at least on an occasional basis (Reinisch, 1990).

Dominant Context

The dominant context in which individuals and relational systems of minoritized GSERD identities, backgrounds, and experiences[2] find themselves, particularly in Westernized cultures, is patriarchal ideology. Patriarchy is a social system that promotes hierarchies and rewards economic, political, and social power to one group over others. Classical patriarchy refers to the domination of man over woman, children, servants, and slaves (Ackerman, 1992). Patriarchy also refers to structures and ideologies which engender the domination and exploitation of the weak and the powerless among us. Thus, by patriarchy, we mean not only the subordination of cisgender women to men, but the "whole structure of Father-ruled society: aristocracy over serfs, masters over slaves, kings over subjects, racial overlords over colonized people" (Reuther, 1983, p. 61). "Patriarchy underlies all forms of chauvinism, racial, cultural, and class domination" (Reuther, 1983, p. 20).

[1] The authors denote equal authorship.

[2] When the authors discuss minoritized gender, sexual, erotic, and relational diversity (GSERD) in individuals and relational systems, they are consistently referring to the GSERD identities, backgrounds, and experiences of said individuals and people; however, for brevity, this nomenclature has been shortened throughout.

DOI: 10.4324/9780429274626-16

In Western societies, patriarchy is situated in the context of Eurocentrism which places Western European societies in a superior position, while placing non-Western, non-European civilizations under categories of "culture." Eurocentrism contributes a viewpoint which expects others to assimilate to the norms of European and Westernization movements (Samassékou, 2011) and largely supports hegemonic masculinity, which defines masculinity through qualities of strength, aggressiveness, and independence. These constructions of masculinity have been shown to be associated with outcomes such as ethnocentrism, racial group marginalization, and negative attitudes toward racial equality and women's equality (O'Neil et al., 2012). The *symptoms* of Eurocentric patriarchal ideology include but are not limited to sexism, cisgenderism, heterosexism, classism, racism, ageism, Eurocentrism, monogamism, sanism, and ableism; it is within this ideological context that people of GSERD identities are minoritized and must engage in visibility management[3] as a response to the role restrictions, bias, and marginalization they experience within the dominant society. In other words, patriarchal ideologies and Eurocentrism contribute to a dominant context that creates difficulty for those GSERD identities that do not fall in line with the assumptive "shoulds" of that context.

"Coming Out" within the Dominant Context

Symptoms of patriarchal ideologies work to keep identities outside cultural norms invisible by blanketing a layer of assumptions of how people "should" be across reality, resulting in widespread erasure of less visible people of minoritized GSERD identities. Thus, one of the first steps to increasing visibility is to deconstruct the term "coming out" as inexact—it implies a single, all-encompassing event. The reality is that people are constantly "coming out" in a variety of situations, for a variety of reasons, and with a wide array of people every day. Conversely, many are choosing *not* to come out just as often and for an equally impressive number of reasons. With rare exception, people do not come out to everyone in all areas of their lives all at once. Many people of minoritized GSERD identities require some level of visibility management. In fact, many people are only visible to a select group of people and invisible to everyone else—some are visible to members of their family of origin but invisible at work, and others are completely visible while their partner may not be, and some are invisible to some or all of the people in their lives.

Barret and Logan (2002) have used the term "selective outness" (p. 73) to describe the complexity involved in coming out in terms of a person's status as a sexual orientation minority, which they report is invisible until made known, as opposed to the visibility for those who are ethnic or racial minorities. We are extending the idea of selective outness to people of minoritized identities as it relates to gender, erotic, and relational identities. Thus, selective outness is the process by which people of minoritized GSERD identities are relatively invisible in the dominant context until they make themselves visible—meaning they tend to be selective with who to be out with, when, and where. Of course, this varies based on the intersection with other identities due to the degree to which a person holds the privileges valued by dominant culture, which enables them to be selective about being out like being white and wealthy. Outness also varies based on the relationships one is in. Indeed, even though folx of minoritized GSERD identities may be out as individuals, such visibility does not automatically transfer to their outness when in partnered relationships (e.g. Vida, a gay man, may be visible about his sexual orientation with his family of origin, but his partner, Darlow, may not be, so they may manage their couple visibility by being only visible as a couple with one family [Vida's] but not with the other family

[3] Visibility management is the degree to which minoritized GSERD-identifying individuals, partners, and other members of a relational system are "out" in varied contexts (Iwasaki & Ristock, 2007). Visibility management is greatly affected by the degree to which the larger society surrounding them practices invisibility management.

[Darlow's]. Selective outness also varies based on where an individual is in their own identity development, as well as the environment in which they exist.

As the environment is predominantly patriarchal, the related *symptoms* for people of minoritized GSERD identities are experienced differently depending upon a variety of factors (e.g. online versus offline, regional area of the country, existence in a rural or urban setting, the ethnic and/or religious make-up of the people within the community). Invisibility management involves the degree to which a society and/or individuals within it fail to validate, recognize, and acknowledge minoritized GSERD identifying individuals and partners (Blumer, Ansara et al., 2013; Blumer & Green, 2011; Green & Blumer, 2013). It is as if the co-construction of an invisibility wall around GSERD folx exists. Visibility management is the degree to which minoritized GSERD identifying individuals, partners, and other members of a relational system are "out" in varied contexts (Iwasaki & Ristock, 2007)—when the context is online it is referred to as electronic visibility management (Twist, Belous et al., 2017; Twist, Bergdall et al., 2017). Visibility management is greatly affected by the degree to which the larger society surrounding them practices invisibility management. People will oftentimes utilize different terminology to describe this phenomenon (e.g. hiding, passing, being discrete, and not being out). Regardless of terminology, the practice itself involves the who, what, when, where, why, and how in terms of each person's and/or relational system's level of public visibility. Mainly in relation to issues of safety, whether it be physical, psychological, or relational in nature, each is placed in a position to make decisions not one time, but repeatedly throughout the span of their lives and respective relationships, with regard to visibility management (Blumer & Green, 2011).

Identities and Identity Development

In the human quest to understand who we are, we experience different iterations of identity which evolve across our lifespan (Erikson, 1959; Marcia, 1966, 1980). Although the concept of identity itself is Eurocentric and ethnocentric (Negy et al., 2003), it is so much a part of who we are in Westernized societies that it is rarely conceptually questioned. When the concept of identity is considered, it is often to dissect it into various components that many believe make up different parts of our overall sense of self—our core identity. Thus, within the development of our core identity is the intersectionality of the different identities that make each of us who we are. These different identities include our racial/ethnic identity, sexual identity, gender identity, religious/spiritual identity, erotic identity, relational identity, etc. The intersections of these various identities impact the development of our identity as a whole and therefore our bi-directional journey through identity statuses. For our purposes, we are focused on the identities of persons of minoritized GSERD identities, backgrounds, and experiences, and the intersectionality of identity management in ethnic and cultural contexts.

Intersection with Ethnic/Cultural Context

The ethnic and cultural context that one is immersed in intersects heavily with identity development and the visibility management that is utilized. For instance, more collectivistic/familistic versus individualistic cultures follow different social norms and traditions (Barrera et al., 2011), which influence the degree to which a culture might practice invisibility management and relatedly how one might manage their own individual or relationship invisibility.

According to Muñoz-Laboy (2008), "In cultures where collectivism is a predominant value, the sexual orientation of individuals is no longer an individual issue, but rather, a struggle between placing an individual's orientation over apparent collective social order" (p. 774). Familistic cultural groups like Latinx, First Nations, Asian, Middle Eastern, Jewish, or religious groups like The Church of Jesus Christ of Latter-Day Saints have their own rules and social norms regarding invisibility management, which, in turn, influences the process of "coming

out" and the visibility management of GSERD folx as they navigate their identity and related development. For example, when I (MLCT) was first working with visible Mormon fundamentalist polygamous family systems, many of my family therapy students and clinical supervisees, who were members of The Church of Jesus Christ of Latter-Day Saints would share with me separately and in private that they had family members one, two, and three generations back who practiced plural marriage,[4] and that they could not imagine practicing polygamy, let alone practicing it and being out about it. Thus, the rules and norms from within the Mormon fundamentalist roots and modern Church of Jesus Christ of Latter-Day Saints dictates that one's (or one's family history) minoritized relational orientation of polygamy ought to be kept secret from religious outsiders (and in some cases from each other).

The familial or community reaction will influence an individual's decisions about their visibility and can even influence identity development itself. Those who conform to the social norms of the family/culture experience benefits such as connection and community. For instance, research conducted by Diaz (1998) indicates that Latinx gay and bisexual men exhibit higher levels of internalized homophobia if there are strong familial ties. Maintaining psychological connectedness with family makes it difficult to denounce the family's homophobia, which can lead to an internalized homophobia (Diaz, 1998; Szymanski & Carr, 2008). Their identity development and visibility management will be strongly intersected with confronting the culture in which their identity is developing.

The invisibility management practices in one's ethnic or cultural context and relatedly one's family or community will heavily influence a GSERD identifying person's visibility management practices. Such factors can influence the individual's ability to follow the religion of the culture, or how they speak around family members. Individuals may find themselves visible to certain siblings but invisible to other family members. The process of visibility management in this context is continuous and complex. This management of visibility can also be influenced by the family's level of acculturation and the individual member's level of acculturation. Individuals who are managing their visibility may feel pressure to conform to traditional gender roles within the community or family context, for instance. Thus, the complexity of ethnic and cultural intersection with visibility management is one that is confounded by many other areas of consideration.

Minoritized GSERD Identities, Identity Development, and Visibility Management

Gender Identity

Historically, in modern Westernized dominant cultural contexts, gender has been primarily tied to traditional religious beliefs (mainly Christianity in the U.S.) and medicalized definitions of sex (DeMaria et al., 2017). In 1954, Dr. Andrea Prader, who was a Swiss physician and pediatric endocrinologist, created the Prader scale. The Prader scale is a staging system from zero to six in which a zero represents the most "right" female genitalia and related reproductive systems and a six the most "right" male genitalia and related systems (Prader, 1954). On this scale, stages one through five represent genitalia that is somewhere along a continuum of intersex (Prader, 1954). This scale was not based on research, but rather on the perceptions of infant genitalia by a medical provider. It is important to understand that there is as much natural diversity that exists in human genitalia as with human faces. Indeed, almost 2% of babies are born along a continuum of intersex—almost as common as people born redheaded (United Nations Office of the High Commissioner for Human Rights, n.d.). But the medicalization of infant genitalia along the Prader scale contributes to a gender binary where natural diversity is instead characterized as abnormal, wrong, and something to be "corrected." This is a predictable result of a

[4] Mormons, particularly in the 19th century, referred to polygamy as "plural marriage."

cultural hyper focus on establishing "sex" differences and on categorizing sex and gender roles. In this context, it becomes reasonable to focus and rate infant genitalia on a scale fitting it into cisgender biological binaries—even to the extent of correcting this via unnecessary and harmful "surgeries" to the genitals of intersex[5] born people (Ansara, 2013).

Given the pervasive religious and medicalized roots for categorizing genitalia (and gender), it is not surprising that people grow up in relational systems that reinforce such conceptualizations. Thus, the dominant ideas about gender identity development and partnered/family relationships are tied to cisgenderism, which is the dominant ideology that delegitimizes people's own understanding of their bodies and genders (Ansara, 2010, 2012; Ansara & Hegarty 2012; Blumer, Ansara et al., 2013). Indeed, one of the earliest manifestations of cisgenderism is the binarizing (or the constructing of the world as if there are only two genders or bodies—male or female, or cisgender or transgender; Ansara, 2012) of infant bodies. This starts in utero when people have ultrasounds performed in part to "sex" their babies (usually around or after 14 weeks into prenatal development) and then hold gender reveal parties based on the findings—whereby decisions around one's gender are made before one is even born. Any other way of conceptualizing one's own gender after this is an act of "coming out"; from this early stage of individual and familial development, we practice invisibility management and set people up to have to practice visibility management, which continues throughout childhood and across the lifespan.

Indeed, although most clinical professionals are familiar with dominant theories of gender identity development like Albert Bandura's (1977) Social Learning Theory, Sandra Bem's (1981) Gender-Schema Theory, and Lawrence Kohlberg's (1966) Cognitive-Developmental Theory, each of these are rooted in cisgenderism; these include ideas such as: (a) one's gender identity stops developing at a certain appropriate age; (b) one's gender is unchanging after a certain point in one's development; (c) one's individual gender remains relatively constant over time and space; and (d) there are really only two "right" genders (man and woman) and anyone whose gender identity is not one of these two then is abnormal, defective, developmentally delayed, or has gender dysphoria. Thus, looking at gender through any one of these dominant theories quickly reveals no room for diversity in one's understanding and/or enacting of one's gender throughout their lifespan, which we know to be a false assumption (Blumer, Green et al., 2013; DeMaria et al., 2017). There is, however, a growing body of gender diversity-based identity development models that have been posited, yet remain limited in their depth and breadth (Boskey, 2014; Diamond et al., 2011; Levitt & Ippolito, 2014; Olson-Kennedy et al., 2016).

Even the concept of gender itself is ethnocentric (Blumer, Green et al., 2013), as it does not accurately describe how individual and relational systems across the globe like cultural groups such as the African-based Yorùbá (Amadiume, 1998; Oyěwùmí, 2010) or the A:shiwi, Hoc̣ak, Lakota, and Dakota, which are First Nations peoples who have lived and continue to live in the post-colonized U.S. (Newman, 2002) situate "gendered" identities and related organizing structures. Anyone not matching these linear cisgender projections of gender and gender identity have to practice visibility management, but this looks different in the context of gender diversity versus sexual orientation as it can be about being visibly gender-non-conforming to "passing" or "going stealth" or simply being treated as the gender one is and not what people think one's gender should be (Blumer & Barbachano, 2008; Goldberg & Kuvalanka, 2018).

Since assumptions about gender are made by parents, medical providers, and religious leaders oftentimes even before birth, the practice of visibility management for gender diverse folx typically has a longer individual history and is even more entrenched than it is for diversity

[5] Intersex refers to those people born with any of several variations in "sex" characteristics, including chromosomes, gonads, sex hormones, or genitals that do not fit the typical definitions for male or female bodies (United Nations Office of the High Commissioner for Human Rights, n.d.).

around sexual, erotic, or relational orientation—as these components of identity tend to occur later in individual and relational systemic development. This means that as a young person grows and changes in their gender identity, they can face parental/care provider and relational grief around their gender. They also frequently have to deal with difficulties navigating and meeting basic human needs surrounding use of public bathrooms, safety from the effects of transphobia[6] in the forms of bullying, protection from physical, emotional, and sexual violence, barriers in dating, partnering, and parenting, etc. It is also important to understand that visibility management is a lifelong process—decisions, as well as experiences outside of one's control, will be made around one's gender diversity for the rest of their life (e.g. name changes, pronoun usage, and legalities) and even in the telling of their life story while alive and after death (e.g. dead naming and what components of one's history goes into an obituary).

For all of the above reasons, and myriad more, it is essential for therapists to practice in ways that are gender-affirming, including in their recognition of and support around visibility management concerns of gender diverse clients. Thus, we have included in this chapter tables of assessments and resources that may be of assistance to clinicians in this endeavor (see Tables 12.1 and 12.2). We do this in part because it is imperative to recognize that clinicians are not immune from cisgenderist thinking and transphobic actions, which is part of the reason that gender diverse clients have to decide whether or not to be visible about their gender with their therapists (Ansara, 2010; Ansara & Hegarty, 2012; Blumer et al., 2012; Blumer, Ansara et al., 2013).

For gender diverse clients, the relationship with a therapist is particularly difficult within which to manage visibility. Oftentimes this is related to mental health providers serving in the role of being the ones to diagnose a client with *gender dysphoria* (American Psychiatric Association, APA, 2013). Frequently, this diagnosis is necessary so that the client can get additional gender-based mental and medical health care support if needed and wanted (Coleman et al., 2012), especially if economic coverage of such support is necessary via mechanisms like private and work-related insurance. Thus, therapists need to do everything they can to minimize the pains of cisgenderism, transphobia, and invisibility for their clinical participants of gender diverse identities.

One small step is recognizing that gender may best be conceptualized not as categorical, but rather as existing along a continuum (Carothers & Reis, 2013), and then helping individuals and relational systems understand and embrace this gendered lens. In this context, gender differences can be seen as reflecting the influences of each individual being's growth, development, and lived experience, and thus gender can be viewed for what it often is, which is relatively amenable to modification (Carothers & Reis, 2013). Indeed, if we are ultimately to help our clients reach a space of identity achievement or acceptance (Marcia, 1993) within and for themselves, then we must first accept that there are more identities around gender than we can possibly even imagine can and do exist. What follows is a case study that demonstrates much of the visibility management concerns outlined here, as well as the intersectionality of various areas of diversity.

Case Study: We Are a Married Couple and Gay Men![7]

Chel and Renée have been living together in a marital relationship in the Southeastern part of the U.S. for 25 years. They are both in their 50s. Until about a year ago, Chel had presented himself publicly as a woman, even though he actually identifies as a gay man to himself, partner,

[6] Transphobia is a term used to refer to the hostile responses people have toward people they perceive as transgender or "trans" (Ansara & Friedman, 2016).

[7] This case study is based on the case study presented by Blumer et al. (2013) in the peer-reviewed article entitled, "Cisgenderism in family therapy: How everyday clinical practices can delegitimize people's gender self-designations." Full reference can be found in the references section of this chapter.

family of procreation, and family of choice/chosen family. Legally, the couple has been recognized as mixed-gender spouses and as they have raised their children, they have been perceived by most as a "straight couple," despite considering themselves to be a gay couple. About a year ago, Chel began taking testosterone, which has meant that he has begun to be perceived as a man. While Chel has been very happy that he has become visible as his authentic gender, such visibility has come at the cost of numerous heterosexual privileges that he and the couple once took for granted (e.g. being read as a heterosexual, cisgender married couple, comfortably displaying affection like hand holding in public spaces). The couple is finding it challenging to adjust to these visibility issues as they are now being read publicly as a gay couple. In their efforts to manage the increased relational stress of dealing with Heterosexism and anti-gay discrimination, as well as Chel's experiences with overt transphobia and cisgenderism, Chel and Renée have sought therapy twice, once shortly before Chel had begun to be perceived as a man in his everyday life and once after this shift.

With their first therapist the clinician assumed that they were a mixed-gender couple, despite their vocalizations that they had selected him because their chosen family had described him as "LGBT-friendly." In this initial assessment, the therapist asked questions about what it was like for Chel to be a mother who now has an empty nest (as their children have grown and left home) and explored how the couple's presumed differing gender roles affected the distribution of household tasks. The therapist also asked questions about their sex life and demonstrated no awareness or sensitivity to Chel's gender identity nor to the logistics of their sexual relationship as two gay-identifying men. Chel felt misgendered and invisible. Renée spent the bulk of the session trying to educate the clinician regarding his inaccurate perceptions about his partner and their relationship.

Despite the very negative and harmful experience with the first therapist, Chel and Renée decided to try another therapist. Their distress increased as Chel's gender had become more visible, so they were even more desperate for therapeutic support. This time, they found a therapist who listed herself as LGBT-affirming and overtly mentioned that she had experience working with transgender-identifying clients on her website. Their first session with this second therapist contrasted sharply with their experience with the previous one. This time, they were immediately visible to the clinician as a similar-gender couple, but she also made several cisgenderist assumptions. For instance, she assumed that both men had always been perceived as men and that they both had been assigned male at birth. She asked whether they found the lack of societal support for their similar-gender relationship to be a problem. When Chel mentioned their children, she asked whether they were the product of former marriages to women, adoption, or surrogacy. Once again, a therapist's initial assessment questions had made them feel invisible in what was supposed to be a therapeutic context.

Sexual Orientation

In the late 19th and early 20th centuries, people within gay subcultures in large cities in the U.S. would speak of "coming out" into gay society. "Coming out" was a term that they borrowed from debutante society, where wealthy young women would come out into high society (Saguy, 2020). Originally, within sexual orientation minority communities, it was a term used mainly to come out within the group. This concept of "coming out" is rooted at least in part in the experiences of people of minoritized sexual orientations (e.g. lesbians, gays, bisexuals, and pansexuals). This is because sexual orientation identity and relational development remains rooted in Heterosexism, which is a system of attitudes, biases, and discrimination that favors dyadic, cisgender woman-man sexuality and relationships (Penelope, 1979), and primarily focuses on heterosexuality as the default sexual identity.

Lesbian and Gay Identity Development Models Because there is a longer history of sexual orientation minorities being visible in Westernized contexts (in comparison to gender, erotic, and relationally diverse persons), there have been several individual identity development models proposed.[8] In addition, there have been mainly two significant couple development models—one focused on male couple development by McWhirter and Mattison (1984) and another focused on female couple development by Clunis and Green (1988). Of note, each of these theories is focused on gay and/or lesbian folx, with little to no consideration for folx identifying as asexual, bisexual, or pansexual.

Bisexual Identity Development Models "Bisexual identity development is even less well-known or theorized" (Dilley, 2002, p. 1). This is true even in the context of exploring sexual orientation minority identity theories and related development. There are two theoretical models that have been developed that were inclusive of bisexuals (as well as other sexual orientation minorities)—the Sexual Identity Formation of Lesbian and Bisexual Women by Rust (1993) and a Sexual Identity Development model that is also inclusive of ethnic/racial differences by Rosario et al. (2004). In addition, there are two theoretical models that are solely focused on bisexual identity development—the Four-Stage Model of Bisexual Identity Development by Weinberg et al. (1995) and a Bisexual Identity Development task-based model by Twining (1983).

Theories about bisexual identity, identity development, and visibility management are important to understand not only in the context of the dominant heterosexual identity development, but also in the context of identity development in lesbian and gay folx. Why? Because bisexual folx experience a double dose of stigma, invisibility, negativity, and phobic responses from both communities—heterosexual and queer (mainly lesbian and gay folx; Dyar, 2017; Twist, 2016b). In relation to bisexual stigma (bi-stigma), biphobia, bisexual invisibility (bi-invisibility) and the prevalence of binegativity, bisexual folx face specific barriers to identity achievement (Marcia, 1993) in the context of their sexual orientation identity development (Dyar, 2017). Arguably, the biggest hurdle is overcoming people's denial of the existence or validity of bisexuality, including within oneself. Relatedly, it hard to visibly "come out" as bisexual—because orientation cannot truly be seen nor assumed by the genders with whom one is partnered (Twist, 2016b)—if one is partnered with a man-identifying person they are read one way, with a woman-identifying person they are read another way, with a genderqueer person they read yet another way (usually as pansexual), and/or if with more than one person they are read as polyamorous. Such barriers for bisexual folx lead many to almost have to name or label their sexual orientation in order to be seen and validated.

Multidimensional/Intersectional Development Models Models of identity and related development, particularly earlier models, have drawbacks. Some of the drawbacks include a lack of attention to relational systemic development and an ignoring of intersectionality of identities. Some multidimensional/intersectional models have emerged, including Diamond's (2008) Dynamic Model of Sexual Identity Development, van Anders' (2015) Sexual Configurations Theory, and Blumer and Green's (2011) Non-Linear Model of Queer Couple Development.[9]Examining

[8] For more information on such theories about minority sexual orientation identity and related development, see Cass's Six-Stage Theory (1979); Coleman's Five-Stage Coming-Out Model (1982); Troiden's Four-Phase Representation of 'Homosexual' Identity Development (1989); D'Augelli's 'Homosexual' Lifespan Development Model (1994); Rhoads' Ethnic Model of Gay Identity (1994, 1997); Savin-Williams' Sexual Identity Trajectories (1998); Fassinger's Model of Lesbian/Gay Identity Formation (1998).

[9] The model was originally called a "Non-Linear Model of Same-Sex Couple Development," by Blumer and Green (2011), but we have updated the name and altered the model slightly to reflect the current and ever-changing nature of GSERD.

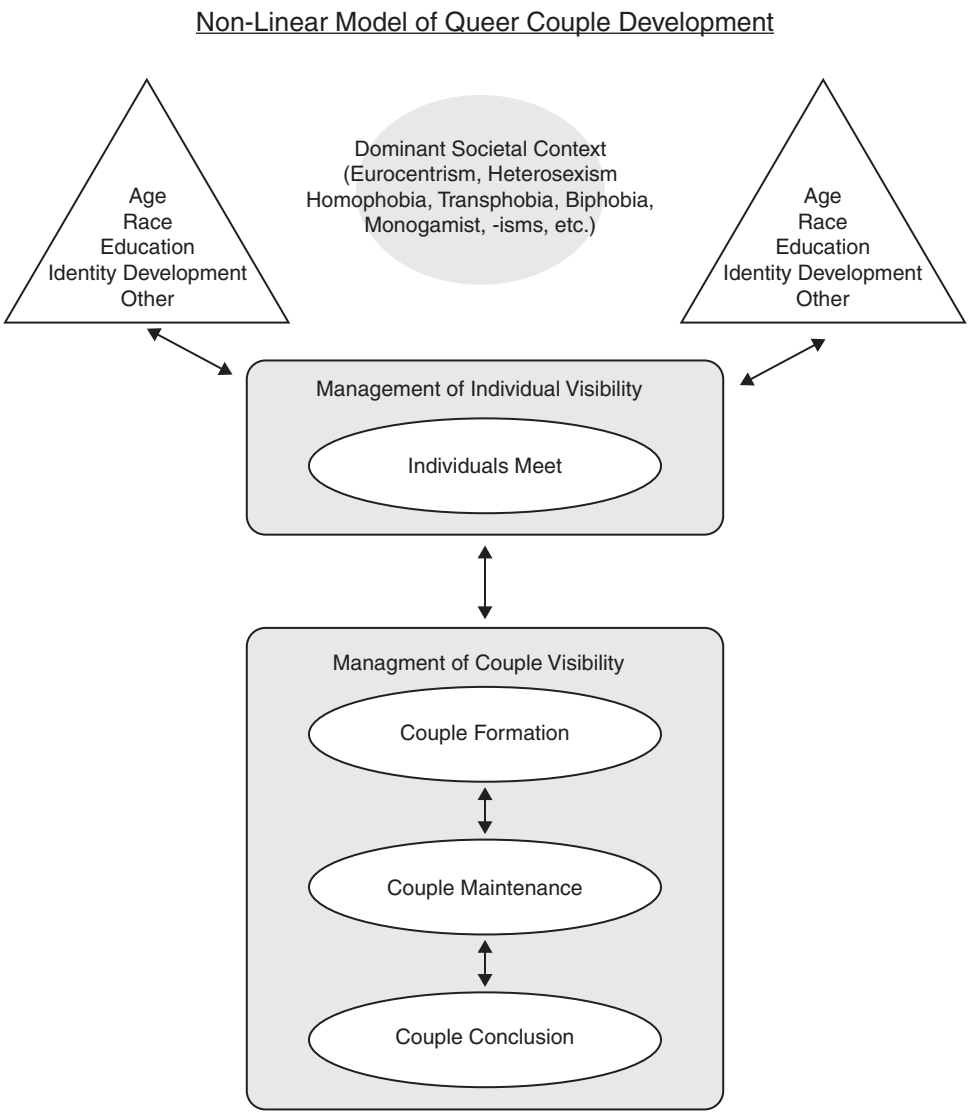


Figure 12.1

Blumer and Green's (2011) model, which is based upon their clinical experience and qualitative research (Blumer, 2008; Blumer & Murphy, 2011; Green, 2009; Green & Blumer, 2010), one sees that their model is based on the intersection of the individuals (and all their identities, backgrounds, and experiences) coming together in a relationship and how this affects individual and relational identity development, including visibility management (for a visual representation of the model, see Figure 12.1).

In Blumer and Green's (2011) original model, the individuals forming a relationship each bring their own individual cultural factors, attachment styles, levels of queer identity development, and their management of these respective identities to the relationship (Blumer & Green, 2011; DeMaria et al., 2017; Green & Blumer, 2013; Hertlein & Blumer, 2013). When two queer individuals meet and form a partnered relationship(s) then they are each bringing the intersection of these various identities into the relationship—all while in the context of a

dominant society that continues to be largely homophobic, heterosexist, transphobic, cisgenderist, biphobic, monogamist, etc. (Blumer, Ansara et al., 2013; DeMaria et al., 2017). If they form a relationship(s), there tends to be a series of stages to their relational development which are typically multidirectional, and include formation, maintenance, and conclusion stages. Because of the invisibility management of the dominant society, which in many cases still does not validate, recognize, and/or acknowledge queerness, the individuals and the couple experience a lack of visibility that affects them as individuals and as a relational system (Blumer & Green, 2011). Indeed, such external influences affect their degree of social support, visibility, and legal rights and recognitions as a relational system. Ultimately these influences affect their experiences of the stages of partnership formation (e.g. being "out" to date, finding people "out" to date), maintenance (e.g. parental rights), and conclusion (e.g. death and bereavement rights) (Blumer & Green, 2011; DeMaria et al., 2017; Green & Blumer, 2013).

Case Study: "No Homo" Bi Guys Allowed!

Andre is a 24-year-old, bisexual, Black American cisgender man who has recently begun exploring sex with other men. Andre has started seeing a therapist on his college campus to process the emotions brought up by these experiences. During a therapy session, he begins crying because at lunch earlier that week a classmate he liked started cracking jokes ("no homo" bi guys allowed) about how she could never date a man who had been on the receiving end of anal sex. The entire table laughed and agreed, making their own jokes about cheating partners and "gay" men. Andre was horrified to hear this said by a woman he had previously held in high regard and felt both invisible and unsafe as the rest of the table laughed. He stated that since then, he had felt a sense of burning shame whenever he thought about his recent experiences with men. The therapist helped him explore the roots of that shame and normalized anal sex as a healthy part of human sexuality. They discussed what it means to be a bisexual cisgender man in the Black American community and how that has affected his self-image. With an affirmative therapist, Andre was able to explore the positive aspects of his sexual identity and construct a sustainable positive sense of self.

Erotic Orientation

Erotic orientation is focused on one's erotic fantasies and stimuli that are arousing (not necessarily sexual) to them (Storms, 1981). Some even make the case that erotic orientation is really the core psychological dimension underlying sexual orientation (and not necessarily gender; Storms, 1981). One's erotic orientation can be conceptualized along a continuum from kinky to non-kinky. The conceptualizing of kink-based engagement as an orientation implies that it is more than a practice or behavior, and instead, is more of a foundational part of one's identity, although some scholars argue that engagement in kink is more of a form of a sexual expression or even a leisure activity (Sprott & Williams, 2019; Williams, 2009). When bondage discipline/dominance and submission/sadism and masochism (BDSM) is categorized as a leisure activity it is due to the similarities between sexual expression and leisure activity—both focus on the development of personal skills, creating a sense of adventure, and stress reduction (Williams, 2009). Moreover, leisure activities are classified along a continuum of casual to serious. For some, BDSM qualifies as serious leisure activity based on criteria that it requires perseverance and planning, it requires acquisition of specialized knowledge, training, and skill, is career-like, and has benefits (Stebbins, 1999; Williams, 2009). For others, BDSM qualifies as a casual leisure

activity because it is spontaneous, short-lived, game-like, or playful, and because specialized skills are not required (Stebbins, 1997; Williams, 2009).

While kink may be an expression or leisure activity to some, researchers have shown that for others kinks/fetishes are present from childhood, just like reports of sexual orientation (Gemberling et al., 2015; Hoff & Sprott, 2009). In this chapter, we are conceptualizing a continuum of erotic orientation and related levels of identity and visibility from no kink engagement to some degree of kink, fetishes,[10] and BDSM.

First, in brief, bondage and discipline involves the use of physical or psychological restraints and various levels of restrictive protocol; dominance and submission involves a degree of power exchange between a dominant (or "top") and a submissive (or "sub" or "bottom") wherein the bottom gives up a measure of control to the Top for a pre-negotiated amount of time; and sadism and masochism involves the use of intense sensations to elicit a variety of responses—sexual and otherwise. The primary focus is on the consent and mutual enjoyment of all participants; before any activity takes place, participants frequently engage in detailed negotiations to determine what will and will not occur during a "play session."

BDSM relationships exist on a continuum from what's known as "24/7" in which participants incorporate power exchange roles in their daily relationships or orient the majority of their sexual activities around it to others who consider it to be a fun activity to spice up the bedroom once in a while. In relation to this, there have been several researchers that have explored the characteristics and demographics of practitioners. For instance, Aaron et al. (2017) found that personality-wise, BDSM practitioners are higher on openness to new experiences than standard/normative samples on the Big Five Inventory, are not significantly different than normal samples on the Adverse Childhood Experiences Questionnaire in terms of trauma in childhood, and on the Experiences in Close Relationship Scale-Short measure attachment style-wise BDSM practitioners tend to be securely attached. Yet, there have been very few studies that have looked at identity development in BDSM practitioners. One study by Yost and Hunter (2012) found that roughly 43% consider BDSM to be an intrinsic part of who they are and that it formed before they can remember; the other 57% attributed their proclivity to external forces such as seeing it in pornography, learning about it from friends, or being introduced via a kinky partner. Moreover, there are no models to date to describe the process of identity development among BDSM practitioners, despite the growing body of research.

A consistent theme in the literature is that people continue to be drawn to BDSM for many reasons. For example, in a national mixed-methods survey study of 362 BDSM practitioners (205 of which had no history of non-suicidal self-injury [NSSI] engagement and 157 had a history of NSSI engagement), the emergent qualitative themes around motivations to engage in BDSM were for pleasure-seeking, to challenge themselves, and to push boundaries (Aaron et al., 2017; Twist, Aaron et al., 2017). In contrast, the themes that emerged around motivations to engage in NSSI alone (17 participants total) focused on pain-avoidance, to feel something other than numbness, and a general relief from unmanageable feelings (Aaron et al., 201; Twist, Aaron et al., 2017).

In the same study, for the participants who were practitioners of BDSM, but no longer engaged in NSSI, their motivations for engaging in BDSM were virtually identical to those who engaged in BDSM and never had engaged in NSSI. Moreover, their motivations for stopping the NSSI activity and continuing the BDSM engagement was reportedly because they felt less depressed, underwent therapy that was helpful, and/or their life situation changed (Aaron et al.,

[10] The experiencing of arousal primarily from things like inanimate objects and/or body parts are fetishes. In many cases, a person may require the fetish or kink to be sufficiently aroused. In the majority of cases, a person's kinks and fetishes are not harmful to oneself or others

2017). Finally, from the quantitative data, the researchers found a significant negative correlation between people who engage in BDSM and NSSI behaviors ($r = -0.226$, $p < 0.01$), which denotes a relationship that engagement in one decreases engagement in the other. An implication from these mixed-methods findings may be that engagement in BDSM can serve as a tool for stopping engagement in NSSI, or at minimum as a coping mechanism for some of the painful effects that NSSI can have on people (i.e. feelings of shame, guilt, isolation, alienation, loneliness, and being damaged and broken; Aaron et al., 2017; Twist, Aaron et al., 2017).

With the arrival of *Fifty Shades of Grey* (James, 2012) in the public sphere, what used to be a hidden subculture in modern times has been brought out into the light of the mainstream (even though the book and related movie series are at best an ill-conceived portrayal of BDSM and at worst more of an example of abuse; Aaron et al., 2017; Twist, Aaron et al., 2017). This has made visibility management somewhat easier simply by the fact that more people are aware of the practice, yet also more difficult as public knowledge does not always equal public acceptance and erotocentrism[11] is rampant (in this case by predominantly non-kinky folx; Skeen, 1999). Thus, practitioners of BDSM (affectionately called "kinksters" within the community) still face public censure, possible loss of livelihood and income, and even legal consequences in most areas of the U.S. (Bezreh et al., 2012). Future research would do well to bridge the aforementioned gaps in the literature, as the subculture shows no signs of going back into hiding.

With this and the dominant patriarchal context in mind, visibility management can be fraught with a great deal of peril as people must choose between living authentically and living safely. Bezreh et al. (2012) conducted a qualitative study exploring how BDSM practitioners managed their visibility and then attended to stigma in multiple contexts. Participants discussed reasons for becoming visible in general, including a desire to be transparent with loved ones, disclosure becoming a necessary part of discussing their BDSM relationship with friends, and as a way to "make the personal political" by disclosing as part of their political activism. The reasons not to become visible were very compelling, including that they did not want to burden friends, did not want to appear "weird," felt a need to "protect" family from the information, and experienced a lack of a sense of safety with close-minded or judgmental friends/acquaintances. Some cited "inappropriate" contexts where information of a sexual nature would be considered taboo or at least very out of place for their reason not to be visible.

Youth with kink interests discussed feeling unsafe disclosing their identity/interests to school counselors or other mental health professionals out of (often justified) fear the provider will "out them" to their parents/care providers, causing unpleasant consequences. These youth cited hearing messages from parents and other meaningful adults that BDSM, and by extension themselves and their interests, were wrong, deviant, mentally ill, or morally depraved causing them to strenuously avoid visibility, as well as question whether they were even good and worthy people. This type of self-questioning, especially as a result of messages received from loved ones, frequently leads to anxiety and depression (Bezreh et al., 2012). Most respondents expressed frustration about the lack of information concerning legal and social protections against discrimination. Many knew someone who had experienced negative interactions with institutions such as the criminal justice system and child services as a result of their BDSM proclivities. One respondent posited a vicious cycle wherein social stigma leads to silence, which leads to more stigma. Several reported initial comfort with their kinkiness as children that turned into internalized prejudice and kinkphobia as they grew into their teen years and adulthood. All respondents expressed frustration that they were unable to discuss such an important aspect of their identity without risking, at times, extreme censure.

[11] Erotocentrism is the belief that one's sexual behavior and attitude are superior to all others and that one's own sexuality is the standard by which others should be judged (Skeen, 1999)

Due to the erotic nature of BDSM activities, disclosure and visibility management in a dating context can become intensely anxiety-provoking. This context comes with its own set of issues as many people fear ostracization and rejection. Risks of disclosure can include abrupt rejection and cutoff, social judgment, partners responding with disgust or shock, and the ever-present fear of being outed. One older participant in a qualitative study actually married someone he had no interest in anymore simply because he had told her his secret and was afraid she would tell their friends and family if they separated (Bezreh et al., 2012).

Visibility management in an employment context can be even more daunting with most people maintaining some level of "stealth" at work, even the ones who try to be as "out" as possible in other aspects of life. Primary concerns in this context are the mental load of maintaining a secret (Lane & Wegner, 1995), being professionally discredited, possibly losing security clearance for those in sensitive positions, the possibility of this information becoming potential blackmail material, and losing their job (Bezreh et al., 2012; Hébert & Weaver, 2015).

As visibility management concerns can be a significant part of the lives of erotic orientation minorities, it is imperative that therapists practice in ways that are affirming, which often does not occur. Indeed, practitioners of BDSM also face significant stigma from the mental health community (Barker et al., 2007; Hoff & Sprott, 2009; Kattari, 2015; Shahbaz & Chirinos, 2016) despite the fact that the American Psychiatric Association (APA), within *The Diagnostic and Statistical Manual of Mental Disorders* (DSM-5), distinguishes between consensual "healthy" behaviors and "unhealthy" behaviors that impact bodily autonomy and cause harm to self or others. Many mental health providers still cling to the common culture-wide misconception that BDSM practitioners are always or almost always victims of abuse or assault despite the fact that this has been debunked (Ansara, 2019; Barker et al., 2007; Brink et al., 2020).

Even in social justice circles, until fairly recently, SM has been presented as inherently anti-feminist, reproduced sexist and heteronormative discourses/relationships, and considered "the epitome of misogyny, sexism, and violence" (Califia, 1980, p. 169). Many mainstream feminists still hold fast to this argument and maintain that one cannot be a feminist if one is engaged in BDSM activities. Even the overt mention of BDSM's focus on consent is met with hostility as they condemn women who actively seek out this type of sexual experience by claiming they have internalized gender bias and self-hatred. Feminist kinksters argue back stating that healthy, well-informed BDSM is in no way conflicting with their feminist identity, citing autonomy, freedom of choice, the heavy focus on consent, and freedom to pursue and explore their own pleasure as supporting reasons (Ritchie & Barker, 2005).

Case Study: I Just Wanna Spoon!

Valentina is a 15-year-old pansexual cisgender female of Latinx descent. Her family include first-generation immigrants from Mexico and her grandmother does not speak English. They are upper middle class due to her father's successful contractor business and her mother's sale of artwork that she makes from materials she finds in nature. Valentina sees her school counselor twice a month to manage mild to moderate depression and issues related to being bullied. During a routine session, Valentina discloses to the counselor that she has fantasies of being tied up and hit with a wooden spoon during sex. She also mentions that she and her girlfriend have experimented with some of these fantasies consensually. Her therapist became alarmed at the disclosure of this information during their session. The therapist's immediate response was to consider this a negative and harming behavior. The therapist did not attempt to unpack these

desires with Valentina by asking questions about her fantasies, sexual experiences, and her relationship with her girlfriend.

The therapist's lack of information and inadequate knowledge about these kinds of sexual fantasies led her to immediately inform Valentina's family that their daughter thinks about being tied up and hit with a wooden spoon during sex. Valentina's family had a severe reaction to this information and called a family meeting where they discussed these desires in a way in which made Valentina vulnerable, uncomfortable, and ashamed. The family punished Valentina by restricting her access to her girlfriend and her social connections, including her online connections. Her parents are of the opinion that her desires are immoral and indicate a deficit in both their parenting and her character.

Ultimately, Valentina was left feeling betrayed by her therapist for disclosing this information to her family. She also felt ashamed and uncomfortable around her family who now knew her sexual fantasy. Relatedly, Valentina started to internalize her therapist's and family's response, which has contributed to her feelings that her desires are wrong and deviant, and that as a result there is something inherently wrong with her.

Relational Orientation

Relational orientation refers to one's pattern of companionate, romantic, and/or sexual attraction to a number of people and/or relationships (Blumer et al., 2014). Relational orientation can be conceptualized along a continuum from non-monogamy to monogamy. What is perceived to be the majority (and therefore dominant) relational orientation in Westernized cultures, especially the U.S., is monogamy, dyadic partnership, marriage, and serial monogamy, despite the fact that many people practice non-consensual non-monogamy or what is more commonly called "cheating," or "infidelity." Indeed, researchers estimate that infidelity rates in heterosexual cisgender couplings range from 40% for women to 60% for men (Block, 2008). Additionally, the world majority does not subscribe to monogamy; indeed, only one in six (or 16%) global societies do (Engber, 2012). On the other side of the relational orientation continuum are the minoritized CNM orientations like polyamory, polygyny, polygamy, polyandry, and others. It is often surprising for folx to learn that CNM is actually the global majority relational orientation; 850 different societies within Africa, Asia, Oceania, and the Middle East practice polygamy, and to a lesser extent in Europe and North America, as well (Altman & Ginat, 1996; Broude, 1994). In between these two extremes along a relational orientation continuum are those that are in the middle like monogamish, open relationships, open marriages, swinging, and group sex. As most clinicians based in Western contexts are usually familiar with the dominant relational orientation majority, in this chapter, we focus our attention on minoritized orientations, specifically polyamory, and in this context we are using the term "polyamory" as a broad umbrella term for myriad forms of CNM at various points along the relational orientation continuum.

Polyamory is a relational orientation that revolves around the concept of multiple simultaneous romantic and/or sexual relationships with the full knowledge and consent of everyone involved (Conley et al., 2013). This differs from infidelity or "non-consensual non-monogamy"; polyamory is consensual non-monogamy, whereas infidelity is non-consensual non-monogamy. Polyamory can be broken down into hierarchical and non-hierarchical forms (Weitzman, 2006). Hierarchical forms include open relationships, in which an established couple "opens" their boundaries to allow other relationships to form, and partners may pursue relationships together or separately; primary partnerships, in which one relationship takes precedence over others and the primary partner may have privileges such as the right to veto other relationships (similar to open relationships but without the prerequisite of former monogamy); and closed polyamorous-families (also known as polyamory-fidelitous) in which a group of partners agree to close their relational boundaries and

restrict their romantic and sexual relationships to only those in the family (Klesse, 2006). These may be hierarchical or not within the family itself (i.e. alpha/beta dynamics or pure egalitarianism). Non-hierarchical forms include solo-polyamory in which one person has multiple romantic and sexual relationships with no distinct hierarchy and various levels of intensity and commitment, and fluid polycules which resemble polyamorous-families but do not incorporate closed boundaries and may consist of partners who date each other, only date one or some partners, and who may or may not have other partners outside of the polycule (Klesse, 2006). Cousins to polyamory that fall along the consensual non-monogamy/monogamy continuum are monogamish relationships and swinging. Monogamish relationships describe romantically monogamous couples who negotiate sexual freedom into their relationship (Clark-Flory, 2012). Swinger relationships vary widely, but can generally be defined as taking lovers for brief sexual encounters without necessarily forming emotional bonds with these people (Peace, 2012). This is by no means an exhaustive account of the wide array of relationship types, styles, and/or orientations that fall under these categories, but is meant to give a general idea of the concept.

Similar to BDSM practitioners, there are no formal models on how a polyamorous identity is formed and developed. Weitzman (2006) detailed several stages of linear polyamorous identity development centered around intra- and interpersonal visibility management but did not put forth a model, rather calling them "milestones in polyamory, and associated growth tasks" (p. 148). These milestones involved acknowledging a polyamorous identity to oneself, informing an extant (and presumably monogamous) partner of the newly acknowledged identity, "negotiating the parameters of an open relationship" (p. 150) should a partner be supportive of the individual's identity, determining the level of visibility management to enact in various contexts, and determining whether or not to include new partners in an existing primary relationship and what that inclusion looks like. Visibility management is an integral part of completing each milestone as many personal, familial, relational, and cultural factors must be considered and managed in order to reach a state of internal equilibrium and satisfaction. Weitzman (2006) considers therapists a key part of managing these factors and encourages clinicians to work with polyamorists to journey through these milestones and the attendant issues that may arise as a result of negotiating a new identity.

The primary issue facing polyamorous people in terms of visibility management is the weight of monogamism, or the dominant belief that the only legitimate relational orientation is being monogamous and the only acceptable relationship form is that of monogamy (Blumer et al., 2014). The weight of this cultural bias contributes to stigma experienced by polyamorous people and relational systems/families, especially if one or more partners in a polyamorous relationship have children (Klesse, 2018). Respondents to one study described experiencing social ostracization as a result of their relational configuration, and the stigma increased dramatically if one member of a perceived couple became pregnant by another partner (Sheff & Adler, 2005). Socially, one study found that polyamorous people were viewed as immoral and less trustworthy than their monogamous peers (Hutzler et al., 2016) and another found that polyamorous people were considered to be "needy" and "confused" (Burris, 2014, p. 265). Concerns about visibility management in regard to children of polyamorous people tend to revolve around the children having to manage other children and parents' reactions to their parents' relationship, specifically managing rejection by peers and cruel remarks from both children and adults (Klesse, 2018). Legally, visibility concerns revolve around custody issues. As late as 2016, 17 states still considered adultery (extramarital affairs) a fineable offense (Rhode, 2016). It is this link between infidelity and immorality in the public eye that contributes to a cultural notion that polyamory is inherently scandalizing to children (much like the assumption regarding LGBT parenting) and that children must be protected from this harmful influence. This bias means that polyamorous parents can and have lost custody of their children due to disapproving spouses and custody judges (Emens, 2004).

In a therapeutic context, polyamorous people have a difficult time finding non-pathologizing therapists who are not only open to working with persons in plural relationships but are also competent with their population (Anapol, 2010). Fuzaylova (2018) found that clients frequently conceal aspects of themselves, including their relational orientation, from their therapist which can lead to mixed therapeutic results and a lack of consistency in treatment. There is a distinct lack of training around consensually non-monogamous relational configurations and orientations and even less around polyamory specifically (Anapol, 2010; McCoy et al., 2015; Schechinger et al., 2018; Stavinoha et al., 2017). This can make going to therapy a frustrating and demoralizing experience as therapists who are not trained to work with this population can cause significant distress in clients. This is exemplified in the case study below in which a therapist blames a client's depression and self-harm behaviors on the fact that she (the client) is polyamorous, creating a feedback loop in which the client's symptoms worsened the more she distanced herself from her "extra" relationships and the polyamorous community. The same client's symptoms improved dramatically after finding a new therapist who was supportive and affirming by encouraging her to pursue her authentic relational orientation (Graham, 2014).

Case Study: If You're Polyamorous Then I Am Out Of Here!

Deja and Andrew are a mixed race, gender, and sexual and relational orientation couple going through a divorce after ten years of marriage. Deja is a 34-year-old bisexual Black cisgender woman who identifies as polyamorous and Andrew is a 37-year-old straight white cisgender man who identifies as monogamous. They have two children—four-year-old Nia and seven-year-old Joseph. Deja disclosed her bisexuality to Andrew before they got married and, while he initially worried she might cheat on him with another woman, they were able to talk through the issue and Andrew's fears were allayed.

Two years ago, Deja became aware of polyamory through a Facebook friend and began researching and reading into it, and even attended a meeting for people interested in learning more about polyamory. While at the meeting, Deja connected with many of the attendees and had a profound realization that not only did the message she was hearing resonate strongly, but that she had been missing feminine energy in her life since shortly after the birth of her son. When she shared this experience with Andrew, however, he became irate and accused her of wanting to cheat on him. Again, they were able to talk through it and Deja dropped the subject for several months during which time she started seeing a therapist as an outlet to process these feelings.

Recently, an acquaintance she met through the polyamory group contacted her and invited her to another meeting at their new location. Andrew saw the message and during the ensuing fight, Deja was forced to come out as polyamorous. Andrew responded with angry rejection and moved out a week later. Now he is using Deja's identity as polyamorous to attempt to discredit her in court and strip her of her parental rights to their children.

GSERD-Affirming Practices

Systemic and relational therapists are not separate from the dominant context in which we all exist—meaning we are socialized and embedded within the same patriarchal ideological system (Reuther, 1983) and when in Western contexts, it is also Eurocentric (Samassékou, 2011). Therefore, it is imperative that therapists do self-of-the-therapist[12] work around working with clinical participants coming from minoritized GSERD identities (Cheon & Murphy, 2007) with the aim of offering clinical services that are affirming.

[12] In this chapter, we are defining self-of-the-therapist as "the active and purposeful use of personal aspects of the therapist to further the aims of therapy" (Tester, 1992, p. 157)

Engaging in intentional self-of-the-therapist work needs to focus on the fostering of increased and ongoing GSERD awareness, knowledge, and skills (Kim et al., 2003). A way to bolster one's GSERD awareness is through conducting assessments in relation to the "-isms" associated with GSERD minoritized populations (see Table 12.1). Perhaps one of the most helpful tools for assessing GSERD and its intersectionality is via the GSERD matrix (see Figure 12.2). Using the

Table 12.1 Gender, Sexual, Erotic, and Relational Diversity Assessments

Assessments around Gender		
Assessment Name	**Assessment Description**	**Assessment Source**
Genderism and Transphobia Scale	The Genderism and Transphobia Scale (GTS) has 32 items measuring violence, harassment, and discrimination toward trans* people.	Hill and Willoughby (2005)
Gender Identity Counselor Competency Scale	The Gender Identity Counselor Competency Scale (GICCS) is 29-items rated on a 7-point Likert scale measuring color competency for working with clients identifying as transgender.	O'Hara et al. (2013)
Gender Focused Genogram	Focused genogram providing a way to explore experiences, issues, identity, patterns, etc., around gender in the context of individual and family/relational system patterns.	DeMaria et al. (2017)
Cisgenderism Measure	The Cisgenderism Measure is a 59-item measure designed to obtain information on one's awareness, knowledge, and skills regarding cisgenderism in professional practice.	Ansara et al. (2018)
Assessments around Sexual Orientation		
Assessment Name	**Assessment Description**	**Assessment Source**
Attitudes Toward Gays and Lesbians Scale	The Attitudes Toward Gays and Lesbians Scale (ATGLS) is a 20-item Likert-type scale measuring attitudes toward lesbian and gay men, specifically looking at condemnation and tolerance.	Herek (1988)
Biphobia Scale	The Biphobia Scale is a 30-item instrument used to measure negative cognitions, affects, and behaviors regarding bisexuality and bisexual individuals.	Mulick (1999)
Heterosexism Scale	The Heterosexism Scale is a 17-item inventory which measures attitudes toward the lesbian, gay, and bisexual community as a whole.	Park (2001)
Modern Homophobia Scale	The Modern Homophobia Scale (MHS) measures contemporary negative attitudes toward gay men and lesbian women.	Mulick and Wright (2002)
Support for Lesbian and Gay Human Rights Scale	The Support for Lesbian and Gay Human Rights Scale (SLGHR) is a 25-item Likert-type scale ranging from 1 to 5 with total scores ranging from 15 to 125. The scale measures individuals' support for human rights in relation to gay and lesbian issues.	Ellis et al. (2003)
Sexual Orientation Counselor Competency Scale	The Sexual Orientation Counselor Competency Scale (SOCCS) is a 29-item measure with three subscales designed to assess a counselor's attitude, skill, and knowledge competencies when working with LGB clients.	Bidell (2005)
Lesbian, Gay, Bisexual Identity Scale	The Lesbian, Gay, Bisexual Identity Scale (LGBIS) is a 27-item measurement assessing where individuals stand on eight different subscales pertaining to their sexual identity as an LGB person	Mohr and Kendra (2011)

(*Continued*)

Table 12.1 (Continued) Gender, Sexual, Erotic, and Relational Diversity Assessments

Bisexual Identity Inventory	The Bisexual Identity Inventory (BII) is a 46-item measurement rated on a 7-point Likert scale measuring facets of bisexual identity.	Paul et al. (2014)
Sexuality Focused Genogram	Focused genogram providing a way to explore experiences, issues, identity, patterns, etc., around sexuality in the context of individual and family/relational system patterns.	Marsh (2017)
Assessments around Erotic Orientation		
Assessment Name	**Assessment Description**	**Assessment Source**
Sadomasochism Checklist	The Sadomasochism Checklist is a 24-item checklist used to assess engagement in sadomasochistic (SM) practices.	Weierstall and Giebel (2017)
Attitudes about Sadomasochism Scale	The Attitudes about Sadomasochism Scale (ASS) is a 23-item scale assessing stereotypical and prejudicial attitude about consensual, sexual sadomasochism.	Yost (2011)
Assessments around Relational Orientation		
Assessment Name	**Assessment Description**	**Assessment Source**
Attitudes Toward Polyamory Scale	The Attitudes Toward Polyamory (ATP) Scale is a 7-item measure of attitudes toward the polyamorous relational orientation.	Johnson et al. (2015)
Monogamism Measure	The Monogamism Measure is a 40-item measure designed to obtain information on one's awareness, knowledge, and skills regarding monogamism in professional practice.	Twist et al. (2018)
Self-of-the-Therapist Assessments around Intersectionality		
Assessment Name	**Assessment Description**	**Assessment Source**
Multicultural Counseling Inventory	The Multicultural Counseling Inventory (MCI) is a 40-item self-report instrument measuring multicultural counseling competencies.	Sodowsky et al. (1994)
Multicultural Awareness, Knowledge, and Skills Survey	The Multicultural Awareness, Knowledge, and Skills Survey (MAKSS) is a 60-item self-report measure looking at perceived multicultural counseling knowledge and awareness.	Kim' et al. (2003)
The LGBT People of Color Microaggressions Scale	The LGBT People of Color (LGBT-POC) Microaggressions Scale is an 18-item self-report scale assessing the unique types of microaggressions experienced by ethnic minority LGBT adults.	Balsam et al. (2011)
LGBT Ally Identity Measure	The LGBT Ally Identity Measure (AIM) is 19-items used to assess the skills to support LGBT persons, knowledge of the LGBT experience, awareness of LGBT oppression, and engage in action among heterosexual allies to the LGBT communities.	Jones, Brewster, and Jones (2014)
Beyond Binaries	Beyond Binaries is a self-assessment exercise to explore the areas of gender, sexual, and relational orientation.	Ochs (2018)
Gender Sexual Erotic and Relational Diversity Matrix	The Gender Sexual Erotic and Relational Diversity (GSERD) Matrix is a visual assessment tool for measuring one's gender, sexual, erotic, and relational orientations along an intersectional multi-axis.	Twist (2018)

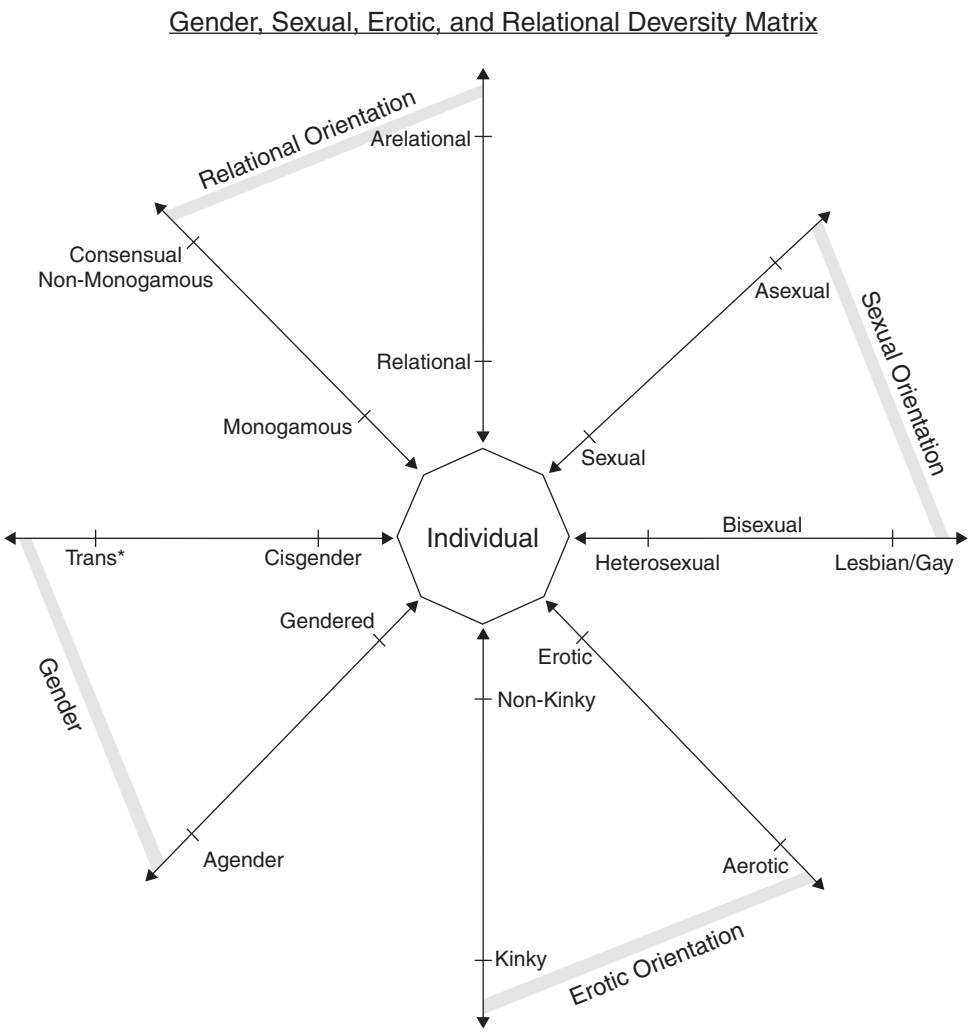


Figure 12.2

GSERD matrix, one can first plot themselves along a continuum of areas of diversity existing for them (and if so to what degree) or not (i.e. sexual to asexual, and gendered to agendered). If the area exists and does so along a continuum for them, they can then plot themselves along the continuum in each relevant area (i.e. cisgender to transgender, and kinky to non-kinky). As a person plots their unique individual intersectionality of GSERD along the matrix, they can use any languaging that makes sense to them in each area (in other words, they are not confined to the words on the matrix—those are meant to be a starting place). Individual GSERD matrices can then be compared and contrasted as an assessment and intervention tool in one's clinical work with members of relational systems.

To bolster one's knowledge of GSERD, information can be gleaned through attending and participating in relevant trainings, receiving specialized consultation and supervision, and/or reading related works (see Table 12.2). Accessing literature like those provided in our table is essential for practitioners in the family and relational therapy field. This is in part because peer-reviewed scholarly GSERD literature is sparse, which means that clinicians need to access other

Table 12.2 Gender, Sexual, Erotic, and Relational Diversity Resources

Resources around Gender Identity		
Resource Name	**Resource Description**	**Resource Source**
Transgender warriors: Making history from Joan of Arc to Dennis Rodman	Survey of historical and contemporary figures who have rejected traditional gender roles.	Feinberg (1996)
The transgender studies reader	Discussion of the evolution of transgender studies and related queer theory.	Stryker and Whittle (2006)
Gender born, gender made: Raising healthy gender-nonconforming Children	Guide for parents, clinicians, and educators on philosophical dilemmas and daily concerns of working with children exploring their gender.	Ehrensaft (2011)
Grrl Alex: A personal journey to a transgender identity	Book combining academic research and personal narrative to describe the author's journey to embracing a transgender identity.	Drummond (2012)
Transgender 101: A simple guide to complex issues	Book describing the history of transgender life, experiences of discrimination, and issues related to gender identity.	Teich (2012)
Gender quest workbook: A guide for teens and young adults exploring gender identity	Workbook to help teens and young adults navigate gender identity and expression.	Testa et al. (2015)
Becoming an ally to the gender-expansive child: A guide for parents and carers	Book for those looking to understand their child's gender experience and gather knowledge on how to accept, support, and protect them.	Bianchi (2017)
How to understand your gender	Guide describing gender in terms of biology, history, and sociology and its affect on relationships and interactions. Includes activities to engage personal development and thought to promote gender exploration.	Iantaffi and Barker (2017)
The gender identity workbook for kids: A guide to exploring who you are	Workbook offering activities to help children explore their identity and navigate gender expression.	Storck (2018)
Resources around Sexual Orientation		
Resource Name	**Resource Description**	**Resource Source**
Pastor I am gay	Book describing the relationship of churches to lesbian/gay populations, aimed at helping ministers and church members to become more supportive of lesbian/gay members.	Bess (1995)
Getting bi: Voices of bisexuals around the world (2nd ed.)	Anthology of personal narratives describing bisexual experience.	Ochs and Rowley (2009)
Counselling ideologies: Queer challenges to heteronormativity	Book discussing deheterosexualizing therapy and providing research and theory for doing so.	Moon (2010)
The invisible orientation: An introduction to asexuality	Book outlining asexuality, misconceptions, and resources for understanding sexual orientation.	Decker (2015)

(*Continued*)

Table 12.2 (Continued) Gender, Sexual, Erotic, and Relational Diversity Resources

Resources around Erotic Orientation		
Resource Name	**Resource Description**	**Resource Source**
Sadomasochism: Powerful pleasures	Book discussing myths about sadomasochism.	Kleinplatz and Moser (2006)
Safe, sane and consensual: Contemporary perspectives on sadomasochism	Book addressing the pathologization of sadomasochism and a discussion on exploring sadomasochism theory and practice in a non-pathologizing way.	Langdridge and Barker (2007)
When someone you love is kinky	Book aimed at helping those who want to learn about kink practices as it relates to understanding and accepting a loved one.	Easton and Liszt (2011)
Sexual outsiders: Understanding BDSM sexualities and communities	Book discussing the experiences of individuals within the BDSM community and misunderstandings surrounding them.	Ortmann and Sprott (2012)
The ultimate guide to kink: Role play, and erotic edge	Collection of essays exploring questions about desire, power, and pleasure.	Taormino (2012)
Becoming a kink aware therapist	Book providing psychotherapists with an understanding of BDSM using research and ethnographic narratives.	Shahbaz and Chirinos (2016)
Resources around Relational Orientation		
Resource Name	**Resource Description**	**Resource Source**
Becoming sister wives: The story of an unconventional marriage	Book by reality-based television personalities describing their experience in plural marriage.	Brown et al. (2012)
The polyamorists next door: Inside multiple-partner relationships and families	Book exploring polyamory, relationship formation, growth and change, and a description of family life.	Sheff (2013)
More than two: A practical guide to ethical polyamory	Guide to ethical polyamory.	Veaux and Rickert (2014)
Designer relationships: A guide to happy monogamy, positive polyamory, and optimistic open relationships	Book describing how to design your life and love to fit your needs, including information on polyamory and open relationships.	Michaels and Johnson (2015)
The ethical slut: A practical guide to polyamory, open relationships, and other freedoms in sex and love (3nd ed.)	A guide for singles and couples looking to explore polyamory in ethically and emotionally sustainable ways.	Hardy and Easton (2017)
Rewriting the rules: An anti self-help guide to love, sex, and relationships (2nd ed.)	Book aimed at helping the reader explore consider their own needs and form their own rules to have healthy relationships.	Barker (2018)

(*Continued*)

Table 12.2 (Continued) Gender, Sexual, Erotic, and Relational Diversity Resources

Resources around GSERD Intersectionality		
Resource Name	**Resource Description**	**Resource Source**
Different sexual worlds: Contemporary case studies of sexuality.	Discussion of human sexuality through case studies, aimed for college-level students.	Skeen (1999)
Who's your daddy? And other writings on queer parenting	Collections of writings from narrative and academic voices contributing to discussions about queer parenting.	Epstein (2009)
LGBT-parent families: Innovations in research and implications for practice	Discussion of research and clinical, methodology, policy and advocacy issues.	Goldberg and Allen (2012)
Border sexualities, border families in schools	Book exploring the experiences of bisexual students, mixed sexual orientation families, and polyamorous-families in schools.	Pallotta-Chiarolli (2010)
Handbook of LGBT affirmative couple and family therapy	Text discussing clinical issues related to LGBT couples and family therapy.	Bigner and Wetchler (2012)
Sexuality and gender for mental health professionals	Guide for practitioners to familiarize them with less common sexualities, genders, and relationship forms and related issues.	Richards and Barker (2013)
Therapeutic conversations with queer youth: Transcending heteronormativity and constructing preferred identities	Practice-based book drawing on queer theory, constructionist philosophy, and cultural study to guide therapeutic work with queer youth working through identity formation.	Tilsen (2013)
The palgrave handbook of the psychology of sexuality and gender	Overview of sexuality and gender and relationship forms.	Richards and Barker (2015)
Focused genograms: Intergenerational assessment of individuals, couples, and families (2nd ed.)	Guide to utilizing the intersystems approach meta-framework and attachment theory to construct focused genograms.	DeMaria et al. (2017)
Life isn't binary: On being both, beyond, and in-between	Guide encouraging self reflection on how we understand dominant society related to binary codes.	Iantaffi and Barker (2019)

resources in order to glean more comprehensive GSERD information. For instance, in a content analysis of literature published in the top 17 family therapy-related journals related to lesbian, gay, and bisexual (LGB) populations between the years of 1996 and 2010, only 2% of the total literature focused on LGB content (Hartwell et al., 2012). In a similar study of the same journals between the years of 1997 and 2009, only 0.0008% of the total literature focused on transgender-related populations and issues (Blumer, Green et al., 2012). In a content analysis focused on kink-related literature between the years of 2016 and 1998, a total of only 53 peer-reviewed journal articles were discovered via an extensive search of the PsycINFO database and none of the articles were in what would commonly be considered a family therapy journal (Curtis et al., 2017). Finally, in a content analysis of the top-tier journal in the family therapy field (Journal of Marital and Family Therapy) from the inception of the journal (1975) to 2014, none of the total

1,563 articles, not even the 35 LGBT articles, focused on queer-identifying folx, polyamorous or polysexual-identifying folx, or multi-partnered or polygamous relational configurations (Blumer & VandenBosch, 2015).

Synthesizing one's awareness and knowledge of GSERD into affirming-clinical skills is often challenging. One way to foster greater success as one is growing in this area is to focus on the developing and fine-tuning of one's GSERD-affirming microskills (Ansara & Twist, 2017; Twist & Ansara, 2017a, 2017b). Counseling microskills are specific skills a practitioner can use to enhance their communication with clinical participants and some consider them the building blocks to establishing an effective therapeutic alliance (Miville et al., 2011).

There are several counseling microskills that can be helpful in establishing alliances with clients of GSERD identities (Ansara, 2019; Ansara & Twist, 2017; Twist, 2020; Twist & Ansara, 2017a, 2017b). These microskills include, but are not necessarily limited to, the following: Microskill I—creating GSERD-positive and affirming spaces and practices (e.g. what kind of images and resources do you have in your space?); Microskill II—establishing reflective practice (e.g. how aware and reflective are you regarding your values, limitations, and beliefs?); Microskill III—considering proactive cueing (e.g. how do you introduce yourself [pronouns]?); Microskill IV—knowing and sharing GSERD-positive literature and resources (e.g. clinicians need to be educated on GSERD, but where?); Microskill V—determining salience (e.g. do not make GSERD part of the problem, if it is NOT a problem!); Microskill VI—validating the impact of "-isms" (e.g. assistance in managing the outside and within communities perspective on being a parent and GSERD?); and Microskill VII—assisting people in navigating sexual health for themselves and in their GSERD relationships (e.g. how do you discuss boundaries, limits, relationship contracts, and safewords/signals?; Twist, 2020).

Conclusion

The dominant context of Eurocentrism and patriarchal ideology constricts us all. As we attempt to navigate a world filled with "shoulds" and "should nots" regarding how we express ourselves and behave, we must simultaneously navigate the discovery of who we are and to whom it is safe to share those discoveries. It is difficult to say when we will move away from viewing white, cisgender, heterosexual, non-kinky, monogamy as the norm in society when so many people exist outside of these boxes.

As the world seems to change, so should our language and understanding of ourselves and others. Moving away from the idea of "coming out" to understanding the process of visibility management is a step in this change. Knowing the difficulty that some face in the constant evaluating of who is safe and who sees them will help us not only in understanding clients, but also in understanding the experiences of the many people around us who have to engage in the visibility management process in every aspect of their lives. Our friends, family, neighbors, and strangers (and for some of the authors—ourselves) alike, who are consistently marginalized and made to feel unsafe by the constructed norms that only harms us, will hopefully see an end to the fear of being seen by those who consciously and unconsciously push harmful constructed norms on them. While we work toward this future, the present begs us to examine ourselves and the ways we reinforce the dominant context of invisibility management and the visibility management that consequently follows for those with marginalized GSERD identities.

References

Aaron, M., Pitagora, D., & Twist, M. (2017). *50 shades happier? The truth about BDSM participants*. https://www.psychologytoday.com/us/blog/standard-deviations/201702/50-shades-happier-the-truth-about-bdsm-participants

Ackerman, D. M. (Ed.). (1992). *Towards our liberation: A new vision of church and ministry in women hold up half the sky: Women in the church in Southern Africa*. Cluster Publications.

Altman, I., & Ginat, J. (1996). *Polygamous families in contemporary society*. Cambridge Press. https://doi.org/10.1017/CBO9780511663987

Amadiume, I. (1998). *Religion, sexuality, and women's empowerment in Nwapa's the Lake Goddess.* In M. Umeh (Ed.), *Emerging perspectives of Flora Nwapa: Critical and theoretical essays* (pp. 515–529). Africa World Press.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). American Psychiatric Association. https://doi.org/10.1176/appi.books.9780890425596

Anapol, D. (2010). *Polyamory in the twenty-first century: Love and intimacy with multiple partners.* Rowman & Littlefield Publishers, Inc.

Ansara, Y. G. (2010). Beyond cisgenderism: Counselling people with non-assigned gender identities. In L. Mood (Ed.), *Counselling ideologies: Queer challenges to heteronormativity* (pp. 167–200). Ashgate. https://doi.org/10.4324/9781315574462-10

Ansara, Y. G. (2012). Cisgenderism in medical settings: How collaborative partnerships can challenge structural violence. In I. Rivers & R. Ward (Eds.), *Out of the ordinary: LGBT lives* (pp. 102–122). Cambridge Scholars Publishing.

Ansara, Y. G. (2019). Trauma psychotherapy with people involved in BDSM/kink: Five common misconceptions and five essential clinical skills. *Psychotherapy and Counselling Journal of Australia, 7*(2). https://pacja.org.au/2019/12/trauma-psychotherapy-with-people-involved-in-bdsm-kink-five-common-misconceptions-and-five-essential-clinical-skills-2/

Ansara, Y. G., & Friedman, E. J. (2016). Transphobia. In A. Wong, M. Wickramasinghe, R. Hoogland, & N. A. Naples (Eds.), *The Wiley Blackwell Encyclopedia of Gender and Sexuality Studies*. Wiley-Blackwell. https://doi.org/10.1002/9781118663219.wbegss217

Ansara, Y. G., & Hegarty, P. (2012). Cisgenderism in psychology: Pathologising and misgendering children from 1999 to 2008. *Psychology & Sexuality, 3*(2), 137–160. https://doi.org/10.1080/19419899.2011.576696

Ansara, Y. G., & Twist, M. L. C. (2017, June). *Developing non-cisgenderist relational and family therapy skills for practice with people of trans and non-binary experience*. Imandari Counselling.

Ansara, Y. G., Twist, M. L. C., VandenBosch, M. L., & Miller-Carlin, J. A. (2018). Cisgenderism measure. *Sexual and Relationship Therapy, 33*(4), 370–376. https://doi.org/10.1080/14681994.2018.1526883

Ansara, Y. G. L. (2013). *Cisgenderism: A bricolage approach to studying the ideology that delegitimises people's own designations of their genders and bodies*. University of Surrey.

Balsam, K. F., Molina, Y., Beadnell, B., Simoni, J., & Walters, K. (2011). Measuring multiple minority stress: The LGBT People of Color Microaggressions Scale. *Cultural Diversity and Ethnic Minority Psychology, 17*(2), 163–174. https://doi.org/10.1037/a0023244

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review, 84*(2), 191–215. https://doi.org/10.1037/0033-295X.84.2.191

Barker, M., Iantaffi, A., & Gupta, C. (2007). *Kinky clients, kinky counselling? The challenges and potentials of BDSM*. Routledge.

Barker, M. J. (2018). *Rewriting the rules: An anti self-help guide to love, sex and relationships*. Routledge. https://doi.org/10.4324/9781315173061

Barrera, A. M., Blumer, M. L., & Soenksen, S. H. (2011). Revisiting adolescent separation-individuation in the contexts of enmeshment and allocentrism. *The New School Psychology Bulletin, 8*(2), 70–82. https://doi.org/10.1037/e741452011-008

Barret, B., & Logan, C. (2002). *Counseling gay men and lesbians: A practice primer*. Brooks/Cole.

Bem, S. L. (1981). Gender schema theory: A cognitive account of sex typing. *Psychological Review, 88*(4), 354–364. https://doi.org/10.1037/0033-295X.88.4.354

Bess, H. H. (1995). *Pastor, I am gay*. Palmer Publishing Company.

Bezreh, T., Weinberg, T. S., & Edgar, T. (2012). BDSM disclosure and stigma management: Identifying opportunities for sex education. *American Journal of Sexuality Education, 7*(1), 37–61. https://doi.org/10.1080/15546128.2012.650984

Bianchi, A. (2017). *Becoming an ally to the gender-expansive child: A guide for parents and carers*. Jessica Kingsley Publishers.

Bidell, M. (2005). Sexual orientation counselor competency sale: Assessing attitudes, skills, and knowledge of counselors working with lesbian, gay, and bisexual clients. *Counselor Education and Supervision, 44*(4), 267–279. https://doi.org/10.1002/j.1556-6978.2005.tb01755.x

Bigner, J. J., & Wetchler, J. L. (Eds.). (2012). *Handbook of LGBT-affirmative couple and family therapy*. Routledge. https://doi.org/10.4324/9780203123614

Block, J. (2008). *Open: Love, sex and life in an open marriage*. Seal Press.

Blumer, M. L. C. (2008). *Gay men's experience of Alaskan society in their coupled relationships* [Doctoral dissertation, Iowa State University). ProQuest Dissertations & Theses Global.

Blumer, M. L. C., Ansara, Y. G., & Watson, C. M. (2013). Cisgenderism in family therapy: How everyday clinical practices can delegitimize people's gender self-designations. *Journal of Family Psychotherapy, 24*(4), 267–285. https://doi.org/10.1080/08975353.2013.849551

Blumer, M. L C., & Barbachano, J. M. (2008). Valuing the gender-variant therapist: Therapeutic experiences, tools, and implications of a female-to-male trans-variant clinician. *Journal of Feminist Family Therapy, 20*(1), 46–65. https://doi.org/10.1080/0895280801907135

Blumer, M. L. C., & Green, M. S. (2011, September 22–25). *The role of same-sex couple development in clinical practice* [Workshop]. American Association for Marriage and Family Therapy Annual Conference, Fort Worth, Texas, United States.

Blumer, M. L. C., Green, M. S., Knowles, S. J., & Williams, A. (2012). Shedding light on thirteen years of darkness: Content analysis of articles pertaining to transgender issues in marriage/couple and family therapy journals. *Journal of Marital and Family Therapy, 38*(1), 244–256. https://doi.org/10.1111/j.1752-0606.2012.00317.x

Blumer, M. L. C., Green, M. S., Thomte, N. L., & Green, P. M. (2013). Are we queer yet? Addressing heterosexual and gender-conforming privilege. In K. Case (Ed.), *Deconstructing privilege: Teaching and learning as allies in the classroom* (pp. 151–168). Routledge.

Blumer, M. L. C., Haym, C., Zimmerman, K., & Prouty, A. (2014). What's one got to do with it?: Considering monogamous privilege. *Family Therapy Magazine, 13*(2), 28–33.

Blumer, M. L. C., & Murphy, M. J. (2011). Alaskan gay males' couple experiences of societal non-support: Coping through families of choice and therapeutic means. *Contemporary Family Therapy, 33*(3), 273–290. https://doi.org/10.1007/s10591-011-9147-5

Blumer, M. L. C., & VandenBosch, M. (2015). Sexual and gender diversity within family therapy: A content analysis of the Journal of Marital and Family Therapy. *Family Therapy* Magazine, 14(2), 84–87. https://www.academia.edu/11786457/Sexual_and_Gender_Diversity_within_Family_Therapy

Boskey, E. R. (2014). Understanding transgender identity development in childhood and adolescence. *American Journal of Sexuality Education, 9*(4), 445–463. https://doi.org/10.1080/15546128.2014.973131

Brink, S. T., Coppens, V., Huys, W., & Morrens, M. (2020). The psychology of kink: A survey study into the relationships of trauma and attachment style with BDSM interests. *Sexuality Research and Social Policy*. https://doi.org/10.1007/s13178-020-00438-w

Broude, G. J. (1994). *Marriage, family and relationships: A cross-cultural encyclopedia*. ABC-CLIO.

Brown, K., Brown, M., Brown, J., Brown, C., & Brown, R. (2012). *Becoming sister wives: The story of an unconventional marriage*. Simon and Schuster.

Burris, C. T. (2014). Torn between two lovers? Lay perceptions of perceptions of polyamorous individuals. *Psychology and Sexuality, 5*(3), 258–267. https://doi.org/10.1080/19419899.2013.779311

Califia, P. (1980). *Sapphistry: The book of lesbian sexuality.* Naiad Press.

Carothers, B. J., & Reis, H. T. (2013). Men and women are from Earth: Examining the latent structure of gender. *Journal of Personality and Social Psychology, 104*(2), 385–407. https://doi.org/10.1037/a0030437

Cass, V. C. (1979). Homosexual identity formation: A theoretical model. *Journal of Homosexuality, 4*(3), 219–235. https://doi.org/10.1300/J082v04n03_01

Cheon, H., & Murphy, M. J. (2007). The self-of-the-therapist awakened: Postmodern approaches to the use of self in marriage and family therapy. *Journal of Feminist Family Therapy, 19*(1), 1–16. https://doi.org/10.1300/J086v19n01_01

Clark-Flory, T. (2012). MONOGAM{ISH}. *Women's Health, 9*(2), 126–129. https://www.womenshealthmag.com/relationships/a19915525/open-relationship/

Clunis, D. M., & Green, G. D. (1988). *Lesbian couples with children*. Seal Press

Coleman, E. (1982). Developmental stages of the coming-out process. *American Behavioral Scientist, 25*(4), 469–482. https://doi.org/10.1177/000276482025004009

Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., Fraser, L., Green, J., Knudson, G., Meyer, W. J., Monstrey, S., Adler, R. K., Brown, G. R., Devor, A. H., Ehrbar, R., Etter, R., Eyler, E., Garofalo, R., Krasic, D. H., Lev, A. I., Mayer, G., Meyer-Bahlbur, H., Hall, B. P., Pfaefflin, F., Rachlin, K., Robinson, B., Schechter, L. S., Tangpricha, V., van Trotsenbur, M., Vitale, A., Winter, S., Whittle, S., Wylie, K. R., & Zucker, K. (2012). Standards of care for the health of transsexual, transgender, and gender-nonconforming people. *International Journal of Transgenderism, 13*(4), 165–232. https://doi.org/10.1080/15532739.2011.700873

Conley, T. D., Ziegler, A., Moors, A. C., Matsick, J. L., & Valentine, B. (2013). A critical examination of popular assumptions about the benefits and outcomes of monogamous relationships. *Personality and Social Psychology Review, 17*(2), 124–141. https://doi.org/10.1177/1088868312467087

Curtis, S., Dhara, J., & Twist, M. L. C. (2017, March). *How clinicians approach BDSM and kink in therapy: A literature review and suggestions for best practices* [Poster presentation]. *University of Wisconsin-Stout Marriage and Family Therapy Program 40th Anniversary Celebration and Conference*. UW-Stout, Menomonie, WI, United States.

D'Augelli, A. R. (1994). Identity development and sexual orientation: Toward a model of lesbian, gay, and bisexual development. In E. J. Trickett, R. J. Watts, & D. Birman (Eds.), *Human diversity: Perspectives on people in context* (pp. 312–333). Jossey-Bass.

Davies, D., & Barker, M. J. (2015). How gender and sexually diverse-friendly is your therapy training? *The Psychotherapist,61,*8–10.https://issuu.com/ukcp-publications/docs/61_the_psychotherapist_autumn_2015

Decker, J. S. (2015). *The invisible orientation: An introduction to asexuality*. Simon and Schuster.

DeMaria, R., Weeks, G. R., & Twist, M. L. (2017). *Focused genograms: Intergenerational assessment of individuals, couples, and families*. Taylor & Francis.

Diamond, L. M. (2008). *Sexual fluidity: Understanding women's love and desire*. Harvard University Press.

Diamond, L. M., Pardo, S. T., & Butterworth, M. R. (2011). Transgender experience and identity. In S. J. Schwartz, K. Luyckx, & V. L. Vignoles (Eds.), *Handbook of identity theory and research* (pp. 629–647). Springer Science Business Media. https://doi.org/10.1007/978-1-4419-7988-9_26

Diaz, R. M. (1998). *Latino gay men and HIV: Culture, sexuality and risk behavior.* Routledge.

Dilley, P. (2002, October). An historical overview of theories of non-heterosexual identity development in college students. *NASPA's NetResults*. https://oregonstate.edu/instruct/cssa556/HistoryGayLesbianBi.htm

Drummond, A. (2012). *Grrl Alex: A personal journey to a transgender identity.* Bramley Press.

Dyar, C. (2017). Bisexual identity development. In K. L. Nadal (Ed.), *The Sage encyclopedia of psychology and gender* (pp. 195–198). Sage.

Easton, D., & Liszt, C. A. (2011). *When someone you love is kinky*. SCB Distributors.

Ehrensaft, D. (2011). *Gender born, gender made: Raising healthy gender-nonconforming children.* Workman Publishing.

Ellis, S. J., Kitzinger, C., & Wilkinson, S. (2003). Attitudes towards lesbians and gay men and support for lesbian and gay human rights among psychology students. *Journal of Homosexuality, 44*(1), 121–138. https://doi.org/10.1300/J082v44n01_07

Emens, E. F. (2004). Monogamy's law: Compulsory monogamy and polyamorous existence. *New York University Review of Law & Social Change, 29*(2), 277–376. https://doi.org/10.2139/ssrn.506242

Engber, D. (2012). Are humans monogamous or polygamous? Archaeologists, anthropologists, and biologists agree: It's complicated. *Slate*. https://slate.com/technology/2012/10/are-humans-monogamous-or-polygamous-the-evolution-of-human-mating-strategies.html

Epstein, R. (2009). *Who's your daddy. And other writings on queer parenting.* Toronto.

Erikson, E. H. (1959). *Identity and the life cycle*. International Universities Press.

Fairbrother, N., Hart, T. A., & Fairbrother, M. (2019). Open relationship prevalence, characteristics, and correlates in a nationally representative sample of Canadian adults. *The Journal of Sex Research, 56*(6), 695–704. https://doi.org/10.1080/00224499.2019.1580667

Fassinger, R. E. (1998). Lesbian, gay, and bisexual identity and student development theory. In R. L. Sanlo (Ed.), *Working with lesbian, gay bisexual, and transgender college students: A handbook for faculty and administrators* (pp. 13–32). Greenwood.

Feinberg, L. (1996). *Transgender warriors: Making history from Joan of Arc to Dennis Rodman.* Beacon Press.

Flores, A. R., Herman, J. L., Gates, G. J., & Brown, T. N. T. (2016). *How many adults identify as transgender in the United States?* The Williams Institute.

Fuzaylova, V. (2018). *Nonmonogamous clients' experiences of identity disclosure in therapy* [Doctoral dissertation, Antioch University]. ProQuest Dissertations and Theses Global.

Gemberling, T. M., Cramer, R., & Miller, R. S. (2015). BDSM as a sexual orientation: A comparison to lesbian, gay, and bisexual identity. *Journal of Positive Sexuality, 1*(3), 56–62. http://journalofpositivesexuality.org/wp-content/uploads/2016/05/BDSM-as-Sexual-Orientation-Gemberling-Cramer-Miller.pdf

Goldberg, A. E., & Allen, K. R. (Eds.). (2012). *LGBT-parent families: Innovations in research and implications for practice*. Springer Science & Business Media.

Goldberg, A. E., & Kuvalanka, K. A. (2018). Navigating identity development and community belonging when "there are only two boxes to check": An exploratory study of nonbinary trans college students. *Journal of LGBT Youth, 15*(2), 106–131. https://doi.org/10.1080/19361653.2018.1429979

Graham, N. (2014). Polyamory: A call for increased mental health professional awareness. *Archives of Sexual Behavior, 43,* 1031–1034. https://doi.org/10.1007/s10508-014-0321-3

Green, M. S. (2009). *The experience of therapy from the perspective of lesbian couple clients and their therapists* [Doctoral dissertation, Iowa State University). ProQuest Dissertations & Theses Global.

Green, M. S., & Blumer, M. L. C. (2010, September). *Same-sex couple development* [Poster presentation]. American Association for Marriage and Family Therapy Annual Conference, Atlanta, GA, United States.

Green, M. S., & Blumer, M. L. C. (2013). Visibility in lesbian and gay families: Managing the family closet. *Family Therapy Magazine*, *12*(1), 28–29.

Hardy, J. W., & Easton, D. (2017). *The ethical slut: A practical guide to polyamory, open relationships and other freedoms in sex and love*. Berkley.

Hartwell, E. E., Serovich, J. M., Grafsky, E. L., & Kerr, Z. Y. (2012). Coming out of the dark: Content analysis of articles pertaining to gay, lesbian, and bisexual issues in couple and family therapy journals. *Journal of Marital and Family Therapy, 38*(s1), 227–243. https://doi.org/10.1111/j.1752-0606.2011.00274.x

Hébert, A., & Weaver, A. (2015). Perks, problems, and the people who play: A qualitative exploration of dominant and submissive BDSM roles. *The Canadian Journal of Human Sexuality, 24*(1), 49–62. https://doi.org/10.3138/cjhs.2467

Herek, G. M. (1988). Heterosexuals' attitudes toward lesbians and gay men: Correlates and gender differences. *Journal of Sex Research*, *25*(4), 451–477. https://doi.org/10.1080/00224498809551476

Hertlein, K. M., & Blumer, M. L. (2013). *The couple and family technology framework: Intimate relationships in a digital age*. Routledge. https://doi.org/10.4324/9780203081815

Hill, D. B., & Willoughby, B. L. (2005). The development and validation of the genderism and transphobia scale. *Sex Roles, 53*(7–8), 531–544. https://doi.org/10.1007/s11199-005-7140-x

Hoff, G., & Sprott, R. A. (2009). Therapy experiences of clients with BDSM sexualities: Listening to a stigmatized sexuality. *Electronic Journal of Human Sexuality, 12*. http://www.ejhs.org/Volume12/bdsm.htm

Hutzler, K. T., Giuliano, T. A., Herselman, J. R., & Johnson, S. M. (2016). Three's a crowd: Public awareness and (mis)perceptions of polyamory. *Psychology & Sexuality, 7*(2), 69–87. https://doi.org/10.1080/19419899.2015.1004102

Iantaffi, A., & Barker, M. J. (2017). *How to understand your gender: A practical guide for exploring who you are*. Jessica Kingsley Publishers.

Iantaffi, A., & Barker, M. J. (2019). *Life isn't binary: On being both, beyond, and in-between*. Jessica Kingsley Publishers.

Iwasaki, Y., & Ristock, J. (2007). The nature of stress experienced by lesbians and gay men. *Anxiety, Stress, & Coping, 20*(3), 299–319. https://doi.org/10.1080/10615800701303264

James, E. L. (2012). *Fifty shades of grey*. Century.

Johnson, S. M., Giuliano, T. A., Herselman, J. R., & Hutzler, K. T. (2015). Development of a brief measure of attitudes towards polyamory. *Psychology & Sexuality*, *6*(4), 325–339. https://doi.org/10.1080/19419899.2014.1001774

Jones, K. N., Brewster, M. E., & Jones, J. A. (2014). The creation and validation of the LGBT Ally Identity Measure. *Psychology of Sexual Orientation and Gender Diversity, 1*(2), 181–195. https://doi.org/10.1037/sgd0000033

Kattari, S. K. (2015). Identity and sexual communication for sexual and gender minorities with physical disabilities. *Sexuality & Culture, 19*(4), 882–899. https://doi.org/10.1007/s12119-015-9298-x

Kim, B. S., Cartwright, B. Y., Asay, P. A., & D'Andrea, M. J. (2003). A revision of the multicultural awareness, knowledge, and skills survey-counselor edition. *Measurement and Evaluation in Counseling and Development, 36*(3), 161–180. https://doi.org/10.1080/07481756.2003.11909740

Kleinplatz, P. J., & Moser, C. (2006). *Sadomasochism: powerful pleasures*. Psychology Press.

Klesse, C. (2006). Polyamory and its 'others': Contesting the terms of non-monogamy. *Sexualities, 9*(5), 565–583. https://doi.org/10.1177/1363460706069986

Klesse, C. (2018). Polyamorous parenting: Stigma, social regulation, and queer bonds of resistance. *Sociological Research Online, 24*(4), 625–643. https://doi.org/10.1177/1360780418806902

Kohlberg, L. (1966). A cognitive-developmental analysis of children's sex-role concepts and attitudes. In E. E. Maccoby (Ed.), *The development of sex differences* (pp. 82–173). Stanford University Press.

Lane, J. D., & Wegner, D. M. (1995). The cognitive consequences of secrecy. *Journal of Personality and Social Psychology, 69*(2), 237–253. https://doi.org/10.1037/0022-3514.69.2.237

Langdridge, D., & Barker, M. (2007). Safe, sane and consensual: *Contemporary perspectives on sadomasochism*. Palgrave MacMillan.

Levitt, H. M., & Ippolito, M. R. (2014). Being transgender: Navigating minority stressors and developing authentic self-presentation. *Psychology of Women Quarterly, 38*(1), 46–64. https://doi.org/10.1177/0361684313501644

Marcia, J. E. (1966). Development and validation of ego-identity status. *Journal of Personality and Social Psychology, 3*(5), 551–558. https://doi.org/10.1037/h0023281

Marcia, J. E. (1980). Identity in adolescence. In R. M. Lerner & L. Steinberg (Eds.) *Handbook of adolescent psychology* (pp. 159–187). Wiley.

Marcia, J. E. (1993). The ego identity status approach to ego identity. In J. E. Marcia, A. S. Waterman, D. R. Matteson, S. L. Archer, & J. L. Orlofsky (Eds.), *Ego identity* (pp. 3–21). Springer. https://doi.org/10.1007/978-1-4613-8330-7_1

Marsh, M. (2017). The sexuality focused genogram. In R. DeMaria, G. Weeks, & M. L. C. Twist, (Eds.), *Focused genograms: Intergenerational assessment of individuals, couples, and families* (2nd ed., pp. 217–248). Taylor & Francis.

McCoy, M. A., Stinson, M. A., Ross, D. B., & Hjelmstad, L. R. (2015). Who's in our clients' bed? A case illustration of sex therapy with a polyamorous couple. *Journal of Sex and Marital Therapy, 41*(2), 134–144. https://doi.org/10.1080/0092623X.2013.864366

McWhirter, D. P., & Mattison, A. M. (1984). *The male couple: How relationships develop*. Prentice-Hall, Inc.

Michaels, M. A., & Johnson, P. (2015). *Designer relationships: A guide to happy monogamy, positive polyamory, and optimistic open relationships*. Cleis Press Start.

Miville, M. L., Redway, J. A., & Hernandez, E. (2011). Microskills, trainee competence, and therapy outcomes: Learning to work in circles. *The Counseling Psychologist, 39*(6), 897–907. https://doi.org/10.1177/0011000011404438

Mohr, J. J., & Kendra, M. S. (2011). Revision and extension of a multidimensional measure of sexual minority identity: The Lesbian, Gay, and Bisexual Identity Scale. *Journal of Counseling Psychology, 58*(2), 234–245. https://doi.org/10.1037/a0022858

Moon, L. (Ed.). (2010). *Counselling ideologies: Queer challenges to heteronormativity*. Routledge.

Mulick, P. S. (1999). *The Biphobia Scale: Development and validation* [Master's thesis]. Western Michigan University. https://scholarworks.wmich.edu/masters_theses/4124/

Mulick, P. S., & Wright, L. W. (2002). Examining the existence of biphobia in the heterosexual and homosexual populations. *Journal of Bisexuality, 2*(4), 45–64. https://doi.org/10.1300/J159v02n04_03

Muñoz-Laboy, M. A. (2008). Familism and sexual regulation among bisexual Latino men. *Archives of Sexual Behavior, 37*(5), 773–782. https://doi.org/10.1007/s10508-008-9360-y

Negy, C., Shreve, T. L., Jensen, B. J., & Uddin, N. (2003). Ethnic identity, self-esteem, and ethnocentrism: A study of social identity versus multicultural theory of development. *Cultural Diversity and Ethnic Minority Psychology, 9*(4), 333–344. https://doi.org/10.1037/1099-9809.9.4.333

Newman, L. K. (2002). Sex, gender, and culture: Issues in the definition, assessment and treatment of gender identity disorder. *Clinical Child Psychology and Psychiatry, 7*(3), 352–359. https://doi.org/10.1177/1359104502007003004

Newport, F. (2018). *In U.S., estimate of LGBT population rises to 4.5%.* Gallup.

Ochs, R. (2018). *Beyond binaries*. https://robynochs.com/beyond-binaries/

Ochs, R., & Rowley, S. E. (2009). *Getting bi: Voices of bisexuals around the world*. Bisexual Resource Center.

O'Hara, C., Dispenza, F., Brack, G., & Blood, R. A. (2013). The preparedness of counselors in training to work with transgender clients: A mixed methods investigation. *Journal of LGBT Issues in Counseling, 7*(3), 236–256. https://doi.org/10.1080/15538605.2013.812929

Olson-Kennedy, J., Cohen-Kettenis, P. T., Kreukels, B. P., Meyer-Bahlburg, H. F., Garofalo, R., Meyer, W., & Rosenthal, S. M. (2016). Research priorities for gender nonconforming/transgender youth: Gender identity development and biopsychosocial outcomes. *Current Opinion in Endocrinology, Diabetes, and Obesity, 23*(2), 172–179. https://doi.org/10.1097/MED.0000000000000236

O'Neil, J. M., Altmaier, E. M., & Hansen, J. C. (Eds.). (2012). *The Oxford handbook of counseling psychology*. Oxford University Press. https://doi.org/10.1093/oxfordhb/9780195342314.001.0001

Ortmann, D. M., & Sprott, R. A. (2012). *Sexual outsiders: Understanding BDSM sexualities and communities*. Rowman & Littlefield Publishers.

Oyeˇwùmí, O. (2010). *Gender epistemologies in Africa: Gendering traditions, spaces, social institutions, and identities*. Palgrave Macmillan. https://doi.org/10.1057/9780230116276

Pallotta-Chiarolli, M. (2010). *Border sexualities, border families in schools*. Rowman & Littlefield.

Park, J. (2001). *Development of the heterosexism scale* [Unpublished doctoral dissertation]. The Pennsylvania State University, University Park.

Paul, R., Smith, N. G., Mohr, J. J., & Ross, L. E. (2014). Measuring dimensions of bisexual identity: Initial development of the Bisexual Identity Inventory. *Psychology of Sexual Orientation and Gender Diversity, 1*(4), 452–460. https://doi.org/10.1037/sgd0000069

Peace, S. L. (2012). *Toward a model of polyamorous identity development* [Doctoral dissertation, John. F. Kennedy University]. ProQuest Dissertations and Theses.

Penelope, J. (1979, November 22–24). *The articulation of bias: Hoof in mouth disease* [Presentation]. Annual Meeting of the National Council of Teachers of English, San Francisco, CA, United States.

Prader, A. (1954). Der genitalbefund beim pseudohermaphroditismus femininus der kengenitalen adrenogenitalen syndroms. *Helv. Paedialr. Ada., 9*, 231–248.

Reinisch, J. M. (1990). *Kinsey institute new report on sex*. St. Martin's Press.

Reuther, R. R. (1983). *Sexism and God-talk: Towards a feminist theology*. SPCK.

Rhode, D. L. (2016). *Adultery: Infidelity and the law.* Harvard University Press. https://doi.org/10.4159/9780674969742

Richards, C., & Barker, M. (2013). *Sexuality and gender for mental health professionals: A practical guide*. Sage. https://doi.org/10.4135/9781473957817

Richards, C., & Barker, M. J. (Eds.). (2015). *The Palgrave handbook of the psychology of sexuality and gender*. Springer. https://doi.org/10.1057/9781137345899

Ritchie, A., & Barker, M. (2005). Feminist SM: A contradiction in terms or a way of challenging traditional gendered dynamics through sexual practice? *Lesbian and Gay Psychology Review, 6*(3), 227–239.

Rosario, M., Schrimshaw, E. W., & Hunter, J. (2004). Ethnic/racial differences in the coming-out process of lesbian, gay, and bisexual youths: A comparison of sexual identity development over time. *Cultural Diversity and Ethnic Minority Psychology, 10*(3), 215–228. https://doi.org/10.1037/1099-9809.10.3.215

Rubin, J. D., Moors, A. C., Matsick, J. L., Ziegler, A., & Conley, T. D. (2014). On the margins: Considering diversity among consensually non-monogamous relationships [Special Issue on Polyamory]. *Journal für Psychologie, 22*(1), 19–37.

Rust, P. C. (1993). "Coming out" in the age of social constructionism: Sexual identity formation among lesbian and bisexual women. *Gender & Society, 7*(1), 50–77. https://doi.org/10.1177/089124393007001004

Saguy, A. C. (2020). *Come out, come out, whoever you are*. Oxford University Press. https://doi.org/10.1093/oso/9780190931650.001.0001

Samassékou, A. (2011). From Eurocentrism to a polycentric vision of the world: Advocacy for a paradigm shift. *Diogenes*, *58*(1–2), 147–158. https://doi.org/10.1177/0392192112448295

Savin-Williams, R. C. (1998). The disclosure to families of same-sex attractions by lesbian, gay, and bisexual youths. *Journal of Research on Adolescents, 8*(1), 49–68. https://doi.org/10.1207/s15327795jra0801_3

Schechinger, H. A., Sakaluk, J. K., & Moors, A. C. (2018). Harmful and helpful therapy practices with consensually non-monogamous clients: Toward an inclusive framework. *Journal of Consulting and Clinical Psychology, 86*(11), 879–891. https://doi.org/10.1037/ccp0000349

Shahbaz, C., & Chirinos, P. (2016). *Becoming a kink aware therapist*. Routledge. https://doi.org/10.4324/9781315295336

Sheff, E. (2013). *The polyamorists next door: Inside multiple-partner relationships and families*. Rowman & Littlefield.

Sheff, E., & Adler, P. A. (2005). *Gender, family, and sexuality: Exploring polyamorous community.* UMI.

Skeen, D. (1999). *Different sexual worlds: Contemporary case studies of sexuality*. Lexington Books.

Sodowsky, G. R., Taffe, R. C., Gutkin, T. B., & Wise, S. L. (1994). Development of the Multicultural Counseling Inventory: A self-report measure of +multicultural competencies. *Journal of Counseling Psychology, 41*(2), 137–148. https://doi.org/10.1037/0022-0167.41.2.137

Sprott, R. A., & Williams, D. J. (2019). Is BDSM a sexual orientation or serious leisure? *Current Sexual Health Reports*, *11*(2), 75–79. https://doi.org/10.1007/s11930-019-00195-x

Stavinoha, S., Harris, J. E., Mollen, D., Porras-Pyland, C., & Rosen, L. (2017). *Psychotherapists' beliefs and attitudes towards polyamory* [Doctoral dissertation, Texas Woman's University]. ProQuest Dissertations and Theses Global. https://twu-ir.tdl.org/bitstream/handle/11274/9361/2017Stavinoha.pdf?sequence=3&isAllowed=y

Stebbins, R. A. (1997). Casual leisure: A conceptual statement. *Leisure Studies, 16*(1), 17–25. https://doi.org/10.1080/026143697375485

Stebbins, R. A. (1999). A contextual analysis of the idea of serious leisure: A study in the sociology of knowledge. *World Leisure & Recreation, 42*(1), 4–9. https://doi.org/10.1080/10261133.1999.9674170

Storck, K. (2018). *The gender identity workbook for kids: A guide to exploring who you are.* New Harbinger Publications.

Storms, M. D. (1981). A theory of erotic orientation development. *Psychological Review, 88*(4), 340–353. https://doi.org/10.1037/0033-295X.88.4.340

Stryker, S., & Whittle, S. (Eds.). (2006). *The transgender studies reader* (Vol. 1). Taylor & Francis.

Szymanski, D. M., & Carr, E. R. (2008). The roles of gender role conflict and internalized heterosexism in gay and bisexual men's psychological distress: Testing two mediation models. *Psychology of Men & Masculinity, 9*(1), 40–54. https://doi.org/10.1037/1524-9220.9.1.40

Taormino, T. (Ed.). (2012). *The ultimate guide to kink: BDSM, role play and the erotic edge*. Cleis Press.

Teich, N. M. (2012). *Transgender 101: A simple guide to a complex issue*. Columbia University Press.
Testa, R. J., Coolhart, D., & Peta, J. (2015). *The gender quest workbook: A guide for teens and young adults exploring gender identity*. New Harbinger Publications.
Tester, S. A. (1992). *The family therapist's use of self: A Delphi study* [Doctoral dissertation, Florida State University]. ProQuest Dissertations and Theses.
Tilsen, J. (2013). *Therapeutic conversations with queer youth: Transcending homonormativity and constructing preferred identities*. Jason Aronson, Incorporated.
Troiden, R. R. (1989). The formation of homosexual identities. *Journal of Homosexuality, 17*(1), 43–74. https://doi.org/10.1300/J082v17n01_02
Twining, A. (1983). Bisexual women: Identity in adult development [Doctoral dissertation, Boston University School of Education]. Dissertation Abstracts International.
Twist, M. L. C. (2016a, April 8). Clinical work with sexually and gender diverse clients. *American Association for Family Therapy eNews*.
Twist, M. L. C. (2016b). Consistency of my bisexual self. *Journal of Bisexuality, 16*(2), 203–208. https://doi.org/10.1080/15299716.2016.1149752
Twist, M. L. C. (2018, November). *A gender, sexual, erotic, and relational diversity matrix: A tool for exploring intersectional queerness* [Continuing Education Workshop]. Society for Scientific Study of Sexuality Annual Conference, Montreal, Quebec, Canada.
Twist, M. L. C. (2019, August). *Exploring intersectional queerness using the GSERD matrix* [Workshop]. American Association for Marriage and Family Therapy Annual Conference, Austin, TX, United States.
Twist, M. L. C. (2020, January). *Affirmative sex therapy practice basics* [Grand Rounds Presentation]. Lorenz Clinic of Family Psychology, Victoria, MN, United States.
Twist, M. L. C., Aaron, M., Pitagora, D., & Curtis, S. (2017, May). *Purposeful pain: What do we know about BDSM and non-suicidal self-injury participants? Survey findings and clinical implications* [Lecture]. Community-Academic Consortium for Research on Alternative Sexualities Alternative Sexualities Annual Conference, Chicago, IL, United States.
Twist, M. L. C., & Ansara, Y. G. (2017a, June). *Developing kink/BDSM-affirmative relational and family therapy skills for practice with people of kink, BDSM, and/or minoritized erotic orientations, identities, and/or relational systems* [Presentation and Workshop]. Imandari Counselling, Glebe, Sydney, Australia.
Twist, M. L. C., & Ansara, Y. G. (2017b, June). *Developing non-monogamist relational and family therapy skills for practice with people of poly, multi-partnered, and consensually non-monogamous identities and/or relational systems* [Presentation and Workshop]. Imandari Counselling, Glebe, Sydney, Australia.
Twist, M. L. C., Belous, C. K., Maier, C. A., & Bergdall, M. K. (2017). Considering technology-based ecological elements in lesbian, gay, and bisexual partnered relationships. *Sexual and Relationship Therapy, 32*(3–4), 291–308. https://doi.org/10.1080/14681994.2017.1397945
Twist, M. L. C., Bergdall, M. K., Belous, C. K., & Maier, C. A. (2017). Electronic visibility management of lesbian, gay, and bisexual identities and relationships in young adulthood. *Journal of Couple & Relationship Therapy, 16*(4), 271–285. https://doi.org/10.1080/15332691.2016.1238798
Twist, M. L. C., Prouty, A. M., Haym, C., & VandenBosch, M. L. (2018). Monogamism measure. *Sexual and Relationship Therapy, 33*(4), 36–381. https://doi.org/10.1080/14681994.2018.1526883
United Nations Office of the High Commissioner for Human Rights. (n.d.). *Intersex awareness*. https://www.unfe.org/intersex-awareness/
van Anders, S. M. (2015). Beyond sexual orientation: Integrating gender/sex and diverse sexualities via sexual configurations theory. *Archives of Sexual Behavior, 44*(5), 1177–1213. https://doi.org/10.1007/s10508-015-0490-8
Veaux, F., & Rickert, E. (2014). *More than two: A practical guide to ethical polyamory*. Thorntree Press, LLC.
Weierstall, R., & Giebel, G. (2017). The Sadomasochism Checklist: A tool for the assessment of sadomasochistic behavior. *Archives of Sexual Behavior, 46*(3), 735–745. https://doi.org/10.1007/s10508-016-0789-0
Weinberg, M. S., Williams, C. J., & Pryor, D. W. (1995). *Dual attraction: Understanding bisexuality*. Oxford University Press.
Weitzman, G. (2006). Therapy with clients who are bisexual and polyamorous. *Journal of Bisexuality, 6*(1–2), 137–164. https://doi.org/10.1300/J159v06n01_08
Williams, D. J. (2009). Deviant leisure: Rethinking "The good, the bad, and the ugly." *Leisure Sciences: An Interdisciplinary Journal, 31*(2), 207–213. https://doi.org/10.1080/01490400802686110
Yost, M., & Hunter, L. (2012). BDSM practitioners' understandings of their initial attraction to BDSM sexuality: Essentialist and constructionist narratives. *Psychology & Sexuality, 3*(3), 244–259. https://doi.org/10.1080/19419899.2012.700028
Yost, M. R. (2011). Attitudes About Sadomasochism Scale. In T. D. Fisher, C. M. Davis, W. L. Yarber, & S. L. Davis (Eds.), *Handbook of sexuality-related measures* (3rd ed., pp. 635–637). Routledge.

13
I Have Too Many Mothers
Queer Families Raising Children

LINDA STONE FISH

Introduction

Since the publication of Lev's, *The Complete Gay and Lesbian Parenting Guide* in 2004, a lot has changed and a lot has stayed the same. The lens of intersectionality (Crenshaw, 1991), while always present in people's lives, has attracted increasing research and clinical attention as affirmative family therapists hope to make clinical work with LGBTQ families more effective. Intersectionality is embedded in the definition of LGBTQ families. Oppression and stigma impact all LGBTQ families but each family is affected differently depending on the particular intersection of social identities at work. Beyond the fact that all LGBTQ families are impacted by oppression, race, class, gender, social location, age, and ableism all act together to uniquely shape the specific experiences of oppression faced by queer families. Even the definition of "family," which can include families of choice who work together to raise children, single queer people raising children, extended families, and queer grandparents raising grandchildren as their own—to name a few—has expanded in recent years.

For the purposes of this chapter, I umbrella the families I write about as queer, and I limit my discussion to families that are raising children. I use the term "queer" because I believe it to be more inclusive than other terms we have at the moment. The point is not to define others but rather to emphasize the liberatory benefits of defining and embracing oneself in the face of oppression. In therapy, I encourage people to define themselves, recognizing that identity may be fluid and that even small shifts in one's understanding of who they are becoming can be clinically useful. Therefore, I encourage clients to explore and recognize what is useful, or not, about their identity-language. Finally, I believe that the term "queer families" serves as a useful umbrella for all parents—LGBTQ or heterosexual—who are raising or have raised queer children.

Queer Families

Queer families are created in multiple ways. Because human beings are the product of sperm and eggs, and we have increasingly sophisticated technology that helps create people, families are made in many different ways. An individual mother, for example, can have a baby from a partner, friend, stranger, donor, incest, rape, one-night stand, or a customer who purchases her eggs or her womb. She can also have a baby while female and then transition to male and choose to be called father or maintain her identity as mother. She can foster, adopt, or raise someone else's baby who may or may not be biologically related to her. An individual father has most of the same options, although without the working uterus—unless, of course, he had one for the birth. Parents can parent jointly, full-time, part-time, alone, with multiple caregivers, and be involved in children's lives forever or not. A queer family can result from heterosexual parents raising queer children or having queer partners, siblings, or extended family. By the very definition of being a queer family, we deconstruct and decolonize family.

DOI: 10.4324/9780429274626-17

Queer Parents

According to the U.S. Census Bureau (2014), the estimates of same-sex couple households include 405,000 female-female adult families and 378,000 male-male adult families; 33,300 of those households are raising children. These census statistics do not take into consideration bisexual individuals nor gender-nonconforming adults. The American Community Survey (ACS), which according to Lofquist (2011) is a representative sample of the nation's population, states that 1% of households are run by LGBTQ adults and of those, 19.4% have at least one child in them. The ACS also showed that 84.1% of parents live with their own children, 72.8% of the children are biological (either from heterosexual relationships or from artificial insemination), and the rest are adopted or step-children (Lofquist, 2011). Recent Gallup poll results (2018) suggest that 4.5% of U.S. adults identify as lesbian, gay, bisexual, or transgender. These statistics, of course, are suspect because of the influence of homophobia, transphobia, and heterosexism. What we know is that between 2 and 3.7 million children are being raised by queer parents and are thriving (Gates, 2015).

While the couple and family therapy (CFT) field may not be contributing much to the research on queer parenting (Hartwell et al., 2012, 2017), there is a growing body of research on lesbian and gay parenting in related fields (Bos et al., 2017; Cocker & Brown, 2010; Goldberg & Smith, 2014; Golombok & Tasker, 1996; Golombok et al., 2014; Guasp et al., 2014; Hicks, 2011; Shapiro et al., 2009; Tasker & Golombok, 2005). The CFT field, however, is more likely to study queer couples and not report about children. Only 20.7% of all recent research reviewed even asked participants about children (Hartwell et al., 2012).

The research from other fields that compares queer parents to heterosexual parents has definitively shown that children thrive in queer families (Bos et al., 2016, 2017; Cornell University, 2017; Gates, 2015). Despite research that shows children thriving, there are still many political and religious influences that discriminate against queer parents. For example, while LGBTQ people are more likely to foster and adopt hard to place children in the system, there are still ten states that restrict their ability to do so if it conflicts with the religious beliefs of the agencies responsible for those children (Bewkes et al., 2018). Furthermore, the last statutory ban on allowing queer parents to adopt children was not struck down until 2016 (Bewkes et al., 2018). These restrictions and some of the dominant discourse around heteronormativity lead to added stress for queer families (Crouch et al., 2014; Garwood & Lewis, 2019). Oppression impacts everyone, but not equally. Macro- and microaggressions persist in our culture despite the impressive strides that have occurred for queer families. Intersectionality continues to impact families and family support. Oppression and its introjection effects have an impact but secure attachments buffer the impact on children (Trub et al., 2017).

We are at the beginning stages of researching transgender and gender-nonconforming parenting. In a recent review of current research, Hafford-Letchfield and colleagues (2018) state that the research is scarce; their review suggests that trans adults' inner and external experiences of transphobia have a direct effect on family functioning. It does appear that the younger the child is when the parent transitions, the easier it is for the child (White & Ettner, 2004), and that family conflict about the transition is more troubling for children than the transition itself. There is research, however, which suggests that some children reject the transition and that this is more prevalent with FtM transition (Hines, 2006).

Transphobia appears to have the impact on queer families that homophobia had a decade or two ago. For example, one study in Canada found that, for queer families, it is more difficult to adopt children if you are a transparent (Ross et al., 2009). Class and race issues seem to exacerbate oppression. Social and family support buffer the effects of transphobia in the same way they buffer homophobia (U.S. Transgender Survey Report, 2015).

Children in Queer Families

Children in queer families are different from each other in multiple ways. How visible they are to themselves and their communities makes a difference. Some children come from families who have the privilege of acknowledging their queerness often and everywhere, and some come from families who are not out in their communities nor in their own homes. Some children are raised in queer families and never know it. When considering intersectionality with queer families, we must consider the differing dynamics that occur in multiple contexts around the safety of being out. For example, it may not be safe to come out for a parent from a conservative religious family who relies on their emotional and financial support to raise their children. Likewise, it may not be safe for some queer families who live in conservative school districts or work for conservative employees to share their social identity. Some bisexual parents, for example, are in heterosexual relationships and choose not to come out because of heteronormativity (Goldberg et al., 2017). Some are visible in their extended family and community and some are not. How visible and with whom also varies. Furthermore, children in the same family have different experiences. Some are bullied at school for having queer parents and some slide through childhood either bully-free or unfazed by contextual judgments (Garwood & Lewis, 2019). Family of origin support varies as well, which can make a huge difference in children's lives (Bertone & Pallotta-Chiarolli, 2014; Oswald, 2002).

Mary, age 42, a Taiwanese-American first-generation cisgender lesbian, was raising two daughters with her white cisgender wife, Jane. Mary's parents did not come to their wedding eight years ago because they were against the marriage. Recently, Mary's parents have shown great interest in grandparenting Mary and Jane's two girls and the girls are starting to feel very close to the grandparents. Mary and her parents have never talked about the abandonment and hostility Mary and Jane felt around their union, and Jane has started to push Mary to confront her parents about it. Jane feels that Mary's parents should apologize for their rocky start, and if not, they should not be allowed to be involved in their grandchildren's lives. Mary disagrees and believes that the act of their interest in the children is apology enough. They seek help for what to do.

Intersectionality Out-ness and freedom to be the family you are is often organized and layered with the cultural intersections of class, race, religion, ethnicity, immigration status, health, and religious affiliations. These intersections are not "passive backdrop(s) for active family process" (Collins, 1998, p. 28) in the lives of queer families. These intersections are active regulators in families' lives and need to be acknowledged as contributors in our clinical work. While most of the early research on queer families was done with white middle-class gay men, the concept of intersectionality is beginning to receive the attention it deserves. For example, recent research (Walker & Longmire-Avital, 2013) has shown that heteronegativity in the Black community negatively influences queer people of color and their sense of self. Unfortunately, some of that heteronegativity is preached through religion. Although Black churches have traditionally been safe havens for Black people living in larger racist social contexts, the intersection of sexual identity and race may be challenging for some.

Mark, age 50, and James, age 48, recently adopted two Black siblings (Martin, age 6, and Sierra, age 8) out of foster care. Mark identifies as Hispanic and was raised in the Catholic Church, while James identifies as Black and was raised as a Southern Baptist. Both men found comfort in the church as children and profound disappointment in their church communities when they came out to themselves as gay. Both men came out to others in their late 20s and blamed the church's stance on homosexuality for their late bloom. James reported:

> I felt like I was born stained. Like God is supposed to love me and think I am perfect but then why did he make me attracted to men and make me imperfect and evil? The only way I could make sense of being gay was that I was bad. It turned me away from God.

Mark had similar experiences. In high school, his mother found a gay porn site on his computer and asked the priest for help. The priest recommended conversion therapy to his parents, and Mark is grateful that his parents did not follow the priest's recommendation. Instead, he denied any same-sex attraction and dated women until he found James.

They came to therapy because Sierra was having night terrors about death. She had a difficult time falling asleep because she was afraid she was going to die; she woke up in the middle of the night calling out for her fathers who she recalled had died in her dreams. Both men were at a loss for how to help her. I asked them to recall their own early childhood and what might have been helpful to them if they were experiencing what Sierra was experiencing. Mark started to cry. He said:

> I just had a profound realization and this is part of the problem, I had God. God protected me at night. I knew he was with me when I slept and I knew he would protect my parents and my family and that I was never alone. I also knew that heaven awaited me if I died so I had nothing to fear. But we can't give our kids God because he died when I came out.

New research on intersectionality and the transgender population shows similar trends to existing research on other queer people. In the 2015 Transgender Discrimination Survey, acts of discrimination were pervasive for all respondents who took the survey, yet the combination of anti-transgender bias and persistent structural and interpersonal acts of racism was especially devastating for multiracial transgender people and other people of color (U.S. Transgender Survey Report, 2015). Compounding variables are that trans people are often under- or unemployed, discriminated against in the workplace, and fired, which leads to poverty with all its burdens. Also similar to research done over the years on queer individuals, family support is a buffer against symptoms related to experiences with oppression.

Intersectional marginalization and oppression are not limited to race. Poverty (Pew, 2013), geographic location, and gender performance are also intersecting variables that have an impact on how families are functioning. Passing for trans people can be a matter of life or death in many places on this planet. The scars of childhood bullying, violence, and microaggressions often stay with adults as they age. Yet, of course, resiliency is found. For example, Singh (2013) interviewed transgender youth of color and found many developed resilient responses to bullying and microaggressions. They learned to advocate for themselves in school, matured quickly, and found social support in online communities.

Resilience Intersectionality must be considered when formulating effective treatment for all families and especially families who bear the burden of multiple oppressions. We must also, however, remember that families develop resources and resiliencies in remarkable ways as they navigate the margins. das Nair and Butler (2012) help clinicians understand how an intersectional lens in clinical work assumes that lived experiences exist in the midst of power imbalances. We help clients identify and limit the effects of domination in their lives and highlight the ways they have blossomed. As das Nair and Butler write, "…we challenge these frontiers further by examining the possibility for power and agency that these individuals and groups of people experience *because* of their intersectional positions" (2012, pp. 2–3). Family therapy with queer families helps to uncover hidden resilience that families have developed, not despite their queerness, but because of it (Harvey & Stone Fish, 2015; Stone Fish & Harvey, 2005).

Just as children in queer families are different from each other in multiple ways, they also share some similarities. Many queer parents have developed resilient skills to cope with the trauma that has occurred living in oppressive communities and families. As we saw from the research above, queer families function the same or better than traditional families and most of the children thrive. Most of the families I see in therapy have developed strong communities of support. That support is an antidote for rejecting family members. Because they are non-traditional, many families find a great deal of love and support from outside the margins. They have relationships with some family members but have often mourned the loss (while still painful) of the rejecting family members, learned that toxic relationships are not good for them and their family, and developed close bonds with each other and their inner circles of support.

I have found that queer families often use therapy well. They are likely to trust the process, include multiple family members, and are open and transparent about the challenges they face. Garanzini and colleagues (2017) actually found the same phenomenon when they worked with gay and lesbian couples. I believe this has much to do with the wisdom that grows from developmental trajectories that are different from the norm and culture in which clients are embedded. In other words, compared to their heterosexual, cisgender peers, queer people usually have an inner wisdom about who they are that is non-negotiable in relationship. It may take years for them to have the strength to acknowledge this inner wisdom but it exists. This knowledge makes them good clients for two reasons. One is that they have grown up knowing that adult knowledge is incomplete and flawed, that there is no absolute truth, and this makes them open to the opinion of others, including the therapists' opinion. They are open to alternative ways of viewing the world because the typical way often devalues them. And, they are good clients because most are not narrow-minded. Narrow-minded clients fit in to the culture in which they were raised, so they rarely have to question dominant discourses. Of course, not all people who fit in are narrow-minded, but clients whose life experiences fit dominant narratives may not have experienced the struggle of dueling perspectives which often lead to being more open to change.

A Family Therapy Model

A family therapy approach that is affirmative and intersectionally sensitive is the key to good treatment. Rebecca Harvey and I created a model of family therapy that we found successful with heterosexual parents raising queer youth (Stone Fish & Harvey, 2005). Because our oppressive dichotomous culture continues to permeate our own and our clients' lives and lenses, the model works for all of the families that I see. Below, I provide two case examples using the model.

The model starts with creating refuge. One key component to refuge is providing an accepting space where the dominant discourse of oppressive practices of marginalization is challenged. Therapy and activism are partners. We understand that dichotomous thinking permeates how we experience ourselves and we challenge those parts that limit our agency. Refuge also means developing an intimate and caring relationship within families in ways that maintain their dignity and challenge them to grow.

Respecting the ways in which intersectional identities inform the therapy process is also part of creating refuge. I identify as a white, cisgender, heterosexual, able-bodied mother from an intergenerational queer family. I rarely explicitly name my identity unless I believe it is useful information or I believe it has created a challenge to the therapeutic relationship. In my individual sessions with adolescents, however, they often ask and I share. I am critically and hyper-aware of how my privileged identities inform my everyday practices and my therapy space, and pay particular attention to knowing when my privilege is not extended to my clients. So, for

example, my childbearing years were filled with multiple privileges that are not extended to some of my clients (low cost, supportive medical community, biological options, community support). I pay particular attention to all of the parts of my identity that could be a barrier to creating refuge with my clients.

The second step in our family therapy approach is difficult dialogues. These are spaces we help create where family members work through conflict and move toward intimacy. These dialogues can be intense, sustained, and filled with emotion or they can be small fits and starts that slowly lead to deeper understandings of each other. These are usually dialogues that family members cannot have without the therapist because at home, they dissolve into interactional patterns of hurt and anger. Difficult dialogues, when facilitated by a therapist who everyone believes is on their side, lead to safer and more intimate relationships.

Nurturing queerness, the third stage of our model, is honoring and using the hidden resiliencies and the gifts that queerness brings. The idea that queerness is a gift is a disruptive one. Many queer adults grew up bi-culturally, navigating the dominant culture while finding home in queer culture. Keeping safe, developing social support, and behaving courageously in frightening situations all create skill sets that are treasures waiting to be mined. I have had clients and participants in workshops who have read something I have written about queerness as a gift tell me that this concept provided great comfort to them and they were appreciative of it. Mining that gift of queerness is the key to good therapy with queer parents. Transformation, hopefully the byproduct of productive therapy, occurs when families generalize the experiences of therapy to nurture their own family and community relationships.

First Case Example

Creating Refuge Laurie called my office and asked if I would see her daughter, Brianna, age 17, in therapy. She said she thought Brianna was depressed. She spent most of her time in her bedroom, was mean to her younger sister, Natalie (age 14), and isolated from Laurie and Laurie's partner, Joy. I told Laurie that as a family therapist, I would expect the whole family to be involved in treatment. My protocol was to see everyone who is raising Brianna first to get an extensive history and their expectations for therapy. Then, I would like to see Brianna alone and then make a decision, in conjunction with Brianna, about who I would see after that. Laurie agreed and we scheduled an appointment.

Four other women accompanied Laurie when she showed up in my waiting room a few weeks later. Laurie is a white cisgender 52-year-old lesbian who teaches theater at a community college. Her partner, Joy, is a 60-year-old white cisgender lesbian family physician. Joy's 83-year-old mother, Rose, a retired nurse living with Laurie and Joy, was also in the waiting room. Brianna and Natalie's other mothers accompanied Laurie, Joy, and Rose to the first session as well. Angela, age 54, is a Black cisgender lesbian who teaches high school and was partnered with Laurie when Laurie gave birth to their two daughters. Angela is now married to Justine, age 45, who identifies as a biracial (mother is Native American and white, and father is Black) cisgender bisexual artist. Justine brought her two sons from a previous heterosexual marriage to the relationship with Angela, and Justine shares custody of them with her ex-husband. Brianna and Natalie split their time equally between the two families. This is an informal custody arrangement that has been working well since Laurie and Angela split up about 12 years ago.

Refuge was established with the mothers and then re-established when I met with Brianna. I also met with Brianna and Natalie multiple times as well as differing dyads and triads throughout the two-year relationship I had with this family. Creating refuge starts with the first phone call. I am careful to not gender anyone when I ask questions about other people and I am open

to multiple relationships and multiple roles. I let my clients define family. Creating refuge is also about attempting to create as much safety as possible in my relationship with my clients and some of that has to do with the structure of the therapy relationship. Before I asked the five women to talk with me about their experience and concerns about Brianna, I talk with them about confidentiality and boundaries. In this case, I asked each of them how they were in relationship with Brianna, who lived where, who else was involved, and basic structural questions.

Then I said,

> so just a little about how I work before we begin. I would like to gather a history about Brianna and your relationships with her. Sometimes it's tough for people to be honest when other people are around so I am more than happy to do this in multiple groups and multiple times. If anyone gets uncomfortable enough that they do not want to be here, I encourage you to take a break or leave. It is not mandatory that we do this together. Also, unless subpoenaed, I will not divulge anything you say in here to anyone else (I explain mandating reporting) and that goes for Brianna as well. In other words, when I meet with her, if she is not a grave danger to herself or to others, I will not share anything she says to me to anyone, including you. If I meet any of you individually and or in dyads, the same occurs. I will often encourage you to say what you said to me to someone else and help you do it, but I will not divulge what you say in here to anyone who is not in the room at the time.

I also try to be transparent as possible about trying to create a space where dominant discourse narratives that police and restrict us do not belong in the therapy room. I do not use those words; yet, I am hypervigilant about protecting the therapy space for ways we all may introject these narratives. For example, if a parent has introjected heteronormativity and talks about their fear of being a good enough parent, I may question where they continue to receive those messages and whether those messages actually fit with their own beliefs. When each person shares their perspective, I lead with curiosity and full attempts at understanding. I attempt to be discerning and not judgmental.

The five women decided that they would like to start the history with all of them in the room, and then each couple would meet with me alone before I saw Brianna. I actually did not see Rose again. Both Brianna and Natalie were birthed when Laurie and Angela were partners and living together. Laurie and Angela chose the sperm donor and together chose to have Laurie carry the babies. They chose a Black sperm donor so that the children would look like both parents. Brianna will have access to information about the sperm donor when she turns 18. She knows this information and has shown no interest at this point in time. Brianna was a happy baby and child and attached and transitioned easily. Laurie and Angela had a heated, intense, sometimes violent relationship but they believe they kept that from the children and it did not impact them.

Laure and Angela split up amicably; Angela moved a few streets down and they have been easily co-parenting since. Laurie and Joy have been together for some time and Angela had multiple relationships before she met Justine. Everyone in the room agreed that the last two years have been hell with Brianna. Before that, she was happy, lovely, and compliant. The precipitating event that brought them into therapy was Natalie telling Rose that she found razor blades and bloody Kleenex in Brianna's room when she was "borrowing" a sweater. Rose told Joy who told Laurie and Laurie angrily confronted Brianna, tearing at her clothes so she could see whether she was cutting, which Brianna denied but Laurie saw evidence of. Brianna ran to a girlfriend's house, came back home the next morning, and has barely spoken to a family member since then. She texts if she needs anything.

When I met with Brianna alone, she corroborated much of the story her family told. What I learned when I saw her alone, however, was that she had a complex and difficult relationship

with her peer group at school and online, and she did not believe that she could share any of that with any of her parental support. Two years before our treatment began, Brianna was asked by one of the popular boys if she would sext him. When she refused, he and his friends started bullying her, calling her a "prude" and harassing her by touching her breasts and pushing her into the lockers at school. She came home from school one afternoon looking frightened, and Joy asked what was up. She told Joy what had happened. That night, Joy told Laurie who told Angela who told Justine. They escalated each other, each reacting with more anxiety in response to each other's worry, and made an appointment with the principal of the school without consulting Brianna.

As anyone who has worked with adolescents knows, this was positively devastating for Brianna yet her parents did not understand what they had done. They were furious with the boy and the school and felt protective of their daughter without having any sense about how their actions might influence her experience in her peer group. She experienced what she considered "drama" from her peer group as well about having so many mothers. She learned all too quickly that she could not share anything with her parents because they would over-react and not be helpful. She said, in the first session with me, "I have too many mothers. I know they all mean well and all that but it's suffocating and overwhelming and I just want to be left alone."

Difficult Dialogues It was important for the lines of communication to open again and our work in therapy became creating space so that Brianna could be honest with her parents. Both Laurie and Angela were devastated by the rupture and blamed each other. In individual sessions, they both also expressed deep fear of Brianna's rejection. They were both able to tie it back to their own parental rejection when they came out. Laurie said:

> I feel the same hostility from Brianna that I felt from my mother and it kills me. I really feel like my mother stopped loving me when I came out to her and I am terrified that the minute Brianna can leave, she'll leave for good and be out of my life forever.

Brianna believed that the work needed to be between her and Laurie and Angela and no one else. Joy felt left out and this was a difficult dialogue addressed in a couple's session with Laurie and Joy. Justine supported Brianna's decision. Brianna's two main concerns were that she was angry that her parents over-reacted and that she believed they were disappointed in her and that was very painful. She only wanted to express these thoughts and feelings once so asked that we meet with both Laurie and Angela together.

The triad met for three sessions interspersed with sessions with other groups and individual family members. Before Brianna could tell her parents about her experiences at school, which she wanted to do, she had to express her outrage at what she considered their over-involvement in a way that they could hear and own. At first, Laurie became defensive and fought back with anger.

> What that boy did was wrong and there is no universe I live in where I'm going to sit around and let my daughter be violated if I have any control over it. And where are the teachers and administration when this shit goes down?

Brianna raged back,

> you see mom, this is why I can't say anything to you. This is why I isolate. This is why I stay quiet. This is why I can't have a fucking discussion with either of you. This is what I get. This righteous bullshit that keeps us from having any reasonable discussion around anything. I'm so sick and tired of it.

Then, she burst into tears. Angela handed her the tissue box and she threw it on the ground. I encouraged Brianna to continue to use her words; with my nonverbals and verbal comments, I encouraged Laurie and Angela to listen with open hearts.

At some point in the conversation, Brianna looked at her mothers and said, "I want to be able to tell you the truth but you both get so anxious and irritable all the time that it's really difficult." Angela started to cry and said,

> honey, that's all we want. I hate how distant we have been. It kills me. It reminds me so much of my relationship with gramma Nene (her mother) and I'm so afraid you are going to cut off from me and never see me again.

Brianna looked at her with amazement. "What? Why would I ever cut off from you, what are you talking about? How is that even relevant here? You're my mother, where am I going to go?" I slowed down the process and explored each person's experience so the other could understand, and a softening and intimate moment occurred that seemed to change the dynamic in the room and eventually in the relationship.

Nurturing Queerness Family therapy discussions became meaningful and fruitful after Brianna, Angela, and Laurie were able to unwrap the knot that had kept them from dialoguing with each other. These discussions were fruitful because we mined the resiliency the family had developed as a queer family. Because there had been multiple extended family ruptures, all family members in Brianna's life were committed to supporting her in the ways she needed to be supported. All the adults were self-aware enough to be able to remember what it was like to be an emerging adult like Brianna. They tapped into the places where they had to parent themselves and what they would have wanted at the time. When Brianna shared some of the ways she had been bullied at school and some of the drama that was occurring in her peer group, her mothers were able to remember similar moments in their own lives and responded in ways they had wished others had responded to them. Angela said:

> I remember someone said something nasty about my clothes being butchy and I was really pissed off. I wish I could have come home and told gramma Nene and she would have said, 'You are beautiful baby. What do you want to do about it and how can I help?' I could never have told her because she hated how I dressed. But that's what I want to say to you Bri, you are beautiful baby. What do you want to do about it and how can I help?

Second Case Example

Creating Refuge Seven years ago, Alex, age 45, and Jackie, age 42, called to schedule a family therapy appointment for themselves and their two children, Micah, age 16, and Sam, age 12. I met with the parents alone to gather information and then scheduled a family session. The presenting problem was that Alex was in the process of transitioning from FtoM, and Micah, and to a lesser extent, Sam, wanted him to stop. At the first session, Alex presented as a white gender-nonconforming female at birth lesbian biological mother of Micah and Sam. Jackie presented as a first-generation Mexican-American cisgender lesbian who has parented the children since Micah was six and Sam was two. Micah and Sam are biological siblings. Their sperm was donated by a close family friend (Mack), a heterosexual white married man with two other children. They live across the country. Micah and Sam spend one or two weeks a summer with their half-siblings and their family.

In the first session, Jackie revealed that she was as uncomfortable with Alex transitioning as the boys were. Alex had recently had top surgery, was taking hormones and wanted to use male pronouns. Alex stated that he felt more authentic as a male and wanted to be out in his

community, his work, with their friends, his family, and the kids' school and that Jackie and the kids were resisting. Out of respect for their wishes, he was pretending to be female but it was starting to irritate him. He believed that Jackie, Micah, and Sam were feeding off each other and feeding into the culture's transphobia, and that they were wrong.

Jackie explained:

> I am sure Alex is right AND there is so much more to what is going on with our resistance. So, I, myself, am a lesbian. I am actually a gold star lesbian[1] and I would have a really hard time if Alex became a man. I had a hard time with the breast surgery and I have no interest in helping him with other surgeries. But I think for the kids it is really different. They are teen-agers going through their own really hard times. Micah has learning challenges and gets bullied enough for that, he is just begging Alex to wait to come out until he goes to college. It is not a life sentence, just a few more years and Alex can't wait and it is pissing us all off. We are not asking you to not be yourself, we are just asking you to wait, goddamn it.

I told the couple that I thought it would be a good idea to meet with them as a couple before we did family therapy so we could boundary off Jackie's concerns from the kids' concerns. They were amenable. We met a few times so that Jackie and Alex could talk about the couple relationship and its viability. I redirected the conversation to the couple whenever Micah or Sam was being used by either parent to justify their experiences. After a few sessions, I recommended we table the couple conversations because there were serious concerns with the children and the couple work was going to take a while and both agreed it could wait. Because Alex's transition was such a volatile topic in the family, and when reactive, both parents were quick to anger, I taught them centering techniques (ways to calm themselves down when reactive) to use before meeting as a family. I met with Micah and Sam alone once before meeting as a family to create refuge and listen to their perspective. They reiterated what both parents had said and both shared frustration with Alex. Sam was less concerned than Micah. He appeared to be well connected to his peer group of staunch soccer and social media junkies (as he identified them) and did not think his friends cared about his parents.

Difficult Dialogues When we met as a family, most of the difficult dialogue was between Alex and Micah. Micah kept calling Alex selfish and too preoccupied with his online community to face the truth about how he was hurting the family. He said:

> You're my mother. I have a father. I don't need another one. I need you to be my mother. I will never get used to you being a man. You aren't. You're like a teen-ager and I need you to be an adult. This is insane. If you show up at my school looking like more of a man than you already do, I will go crazy. You can do whatever you want to do, just not in front of my friends.

Alex sometimes reacted from a parental position of setting limits with Micah and asking him to treat him with respect as a parent to feeling hurt and insulted by what he considered Micah's transphobia. I encouraged Alex to see if he could ground himself enough to pay attention to what Micah's reactions were saying about Micah's experience. "You've been a great mother to Micah and Sam. While you might not think about yourself that way anymore, or maybe you never have, this has been their experience and they need to share their fears with you." Alex listened as both kids talked about their fears. They shared stories they heard about trans people getting killed and awful comments their friends and some teachers had made about trans

[1] This is a vernacular term which means only having sex with women. The term may be offensive because it implies gender as a constant but at the time, I did not challenge it.

people. Micah said that he understood that Alex needed to be himself and that he should be able to, he just begged him to wait for two more years. "This way, I can go to college and no one will know you," Micah said.

Alex responded angrily, "How can you talk about me like that? Would you rather I was dead because that is how I feel if I can't be myself. I can't win. This is completely unproductive." He stood up and walked out. I asked Jackie to go find him and help him use his centering techniques enough to come back into session. Micah and Sam were scared and frustrated. Sam said, "It's like she's putting us in a position where she's saying, you have to love me no matter what I do and that's not fair. We wouldn't make her do that." I said:

> You are great kids and you have a great family and that has a lot to do with how well your mother loves you. He wants you to see him how he sees himself. The love seems pretty unconditional to me.

Alex and Jackie walked back in and Alex apologized for his outburst. He shared his frustration and his love and said he understood Micah's position, he just wished Micah felt differently. We talked about some compromising possibilities. Alex said he could not wait until Micah went to college to transition (cut his hair, grow facial hair, and wear men's clothing) but he would wait until the school year ended. Micah said he would try to be nicer to Alex and respect that he is a person too, not just his mother.

Nurturing Queerness Alex and Jackie met for couple therapy for the next couple of years, and I would periodically see Micah and Sam as well and the family. Jackie realized that she could not stay with Alex and we worked out a co-parenting relationship that actually seemed to work better for everyone in the family. Jackie moved about a mile away and the children split their time between them in a way that was fluid and comfortable. Micah seemed to embrace his older brother position and helped Sam with the transition in a way that all members of the family appreciated. Micah went away to college and sophomore year decided to transfer closer to home and switch majors. To save money, he chose to live with Alex and his new girlfriend who is a cisgender heterosexual white woman. He came in to talk about some anxiety he was experiencing in college senior year and I asked him about his relationship with Alex who he called by his first name. He said:

> I love Alex, he's a good guy. He's sort of like the same person but not really, I don't know. I guess I miss my mother but she's sort of like still here. Shit, I sure have learned a lot about gender fluidity. I mean, it's just a construct, right? I'm taking this gender studies course and I talked about him for the first time in class. It felt great to be an expert on it. Nobody else in class had my experience. It was awesome, actually.

Conclusion

While generalizations about queer parents and their children in therapy are impossible, there are some common themes that help therapy progress. Oppression impacts everyone but not equally. It can wear one down and it can help people develop talents that are useful when life throws inevitable challenges. Affirmative and intersectionality-informed family therapy mines the resilience that queer families bring with them. Most queer parents take parenting seriously and have a profound understanding for the need to support their children as they grow. They also understand that their children have their own path toward self-discovery that may not be the one they expected for them. Often, queer families are less restricted by the dominant discourse around gender and sexuality. They have also developed positive social support systems that they resource when challenged.

Family therapists who enhance the family's resources will be successful. They also need to challenge the patterns that get in the way of development. Conflict resolution that leads to more intimate interactions may not be something queer families have been exposed to enough to bring into therapy. It needs to be taught through facilitating difficult dialogues. When we can acknowledge differences, believe we are understood and loved, and that our loved ones are going to stay in relationship with us forever, we can face the challenges the world inevitably throws at us. Hopefully, the challenges continue to lessen and the world becomes a safer place for queer families to thrive.

References

Bertone, C., & Pallotta-Chiarolli, M. (2014). Putting families of origin in the queer picture: Introducing this special issue. *Journal of GLBT Family Studies, 10*(1–2), 1–14. https://doi.org/10.1080/1550428X.2013.857494

Bewkes, F. J., Mirza, S. A., Rooney, C., Durso, L. E., Kroll, J., & Wong, E. (2018). *Welcoming all families: Discrimination against LGBT foster and adoptive parents hurts children*. Center for American Progress. www.americanprogress.org.

Bos, H., Knox, J. R., Gelderen, L. R., & Gartell, N. L. (2016). Same-sex and different-sex parent households and child health outcomes: Findings form the national survey of children's health. *Journal of Developmental and Behavioral Pediatric, 37*(3), 179–187. https://doi.org/10.1097/DBP.0000000000000288

Bos, H., Kuyper, L., & Gartell, N. K. (2017). A population-based comparison of female and male same-sex parent and different-sex parent households. *Family Process, 57*(1), 148–164. https://doi.org/10.1111/famp.12278

Cocker, C., & Brown, H. C. (2010). Sex, sexuality and relationships. *Adoption and Fostering, 34*(1), 20–32. https://doi.org/10.1177/030857591003400103

Collins, P. H. (1998). Intersections of race, class, gender, and nation: Some implications for black family studies. *Journal of Comparative Family Studies, 29*(1), 27–36. https://doi.org/10.3138/jcfs.29.1.27

Cornell University. (2017). *What we know, "What does the scholarly research say about the well-being of children with gay or lesbian parents?"* Cornell University: The Public Policy Research Portal.

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review, 43*(6), 1241–1299. https://doi.org/10.2307/1229039

Crouch, S. R., Waters, E., McNair, R., Power, J., & Davis, E. (2014). Parent-reported measures of child health and wellbeing in same-sex parent families: A cross-sectional survey. *BMC Public Health, 14*(635), 1–12. https://doi.org/10.1186/1471-2458-14-635

das Nair, R., & Butler, C. (2012). Introduction. In R. das Nair & C. Butler (Eds.), *Intersectionality, sexuality and psychological therapies: Working with lesbian, gay and bisexual diversity*. BPS Blackwell. https://doi.org/10.1002/9781119967613

Gallup Poll. (2018). www.news.gallup.com/poll/234863/estimate-lgbt-population-rises.aspx

Garanzini, S., Yee, A., Gottman, J., Gottman, J., Cole, C., Preciado, M., & Jasculca, C. (2017). Results of Gottman method couples therapy with gay and lesbian couples. *Journal of Marital and Family Therapy, 43*(4), 674–684. https://doi.org/10.1111/jmft.12276

Garwood, E., & Lewis, N. H. (2019). Where are the adult children of LGBTQ parents? A critical review. *Journal of Family Theory and Review, 11*(4), 592–610. https://doi.org/10.1111/jftr.12348

Gates, G. J. (2015). Marriage and family: LGBT individuals and same-sex couples. *The Future of Children, 25*(2), 67–87. https://doi.org/10.1353/foc.2015.0013

Goldberg, A. E., Allen, K. R., Ellawala, T., & Ross, L. E. (2017). Male-partnered bisexual women's perceptions of disclosing sexual orientation to family across the transition to parenthood: Intensifying heteronormativity or queering family? *Journal of Marital and Family Therapy, 44*(1), 150–164. https://doi.org/10.1111/jmft.12242

Goldberg, A. E., & Smith, J. Z. (2014). Predictors of parenting stress in lesbian, gay, and heterosexual adoptive parents during early parenthood. *Journal of Family Psychology, 28*(2), 125–137. https://doi.org/10.1037/a0036007

Golombok, S., & Tasker, F. (1996). Do parents influence the sexual orientation of their children? Findings from a longitudinal study of lesbian families. *Developmental Psychology, 32*(1), 3–11. https://doi.org/10.1037/0012-1649.32.1.3

Golombok, S., Mellish, L., Jennings, S., Casey, P., Tasker, F., & Lamb, M. E. (2014). Adoptive gay father families: Parent–child relationships and children's psychological adjustment. *Child Development, 85*(2), 456–468. https://doi.org/10.1111/cdev.12155

Guasp, A., Statham, H., & Jennings, S. (2014). *Different families: The experience of children with lesbian and gay parents*. Stonewall.

Hafford-Letchfield, T., Cocker, C., Rutter, D., Tinarwo, M., McCormack, K., & Manning, R. (2018). What do we know about transgender parenting? Findings from a systemic review. *Health and Social Care in the Community, 27*(5), 1–15. https://doi.org/10.1111/hsc.12759

Hartwell, E. E., Serovich, J. M., Grafsky, E. L., & Kerr, Z. Y. (2012). Coming out of the dark: Content analysis of articles pertaining to gay, lesbian, and bisexual issues in couple and family therapy journals. *Journal of Marital and Family Therapy, 38*(s1), 227–243. https://doi.org/10.1111/j.1752-0606.2011.00274.x

Hartwell, E. E., Serovich, J. M., Reed, S. J., Boiswert, D., & Falbo, T. (2017). A systemic review of gay, lesbian, and bisexual research samples in couple and family therapy journals. *Journal of Marital and Family Therapy, 43*(3), 482–501. https://doi.org/10.1111/jmft.12220

Harvey, R. G., & Stone Fish, L. (2015). Queer youth in family therapy. *Family Process, 54*(3), 396–417. https://doi.org/10.1111/famp.12170

Hicks, S. (2011). *Lesbian, gay and queer parenting: families, intimacies, genealogies*. Palgrave Macmillan. https://doi.org/10.1057/9780230348592

Hines, S. (2006). Intimate transitions: Transgender practices of partnering and parenting. *Sociology-The Journal of the British Sociological Association, 40*(2), 353–371. https://doi.org/10.1177/0038038506062037

Lev, A. I. (2004). *The complete gay and lesbian parenting guide*. Penguin Press.

Lofquist, D. (2011). *Same-sex couple households: American Community Survey briefs.* www.census.gov/prod/2011pubs/acsbr10-03.pdf

Oswald, R. (2002). Resilience within the family networks of lesbians and gay men: Intentionality and redefinition. *Journal of Marriage and Family, 64*(2), 374–383. https://doi.org/10.1111/j.1741-3737.2002.00374.x

Pew Research Global Attitudes Project. (2013). *The global divide on homosexuality: Greater acceptance in more secular and affluent countries*. http://www.pewglobal.org/2013/06/04/the-global-divide-on-homosexuality/

Ross, L. E., Epstein, R., Anderson, S., & Eady, A. (2009). Policy, practice, and personal narratives: Experiences of LGBTQ people with adoption in Ontario, Canada. *Adoption Quarterly, 12*(3–4), 272–293. https://doi.org/10.1080/10926750903313302

Shapiro, D. N., Peterson, C., & Stewart, A. J. (2009). Legal and social contexts and mental health among lesbian and heterosexual mothers. *Journal of Family Psychology, 23*(2), 255–262. https://doi.org/10.1037/a0014973

Singh, A. A. (2013). Transgender youth of color and resilience: Negotiating oppression and finding support. *Sex Roles: A Journal of Research*, *68*(11–12), 690–702. https://doi.org.pnw.idm.oclc.org/10.1007/s11199-012-0149-z

Stone Fish, L., & Harvey, R. G. (2005). *Nurturing queer youth: Family therapy transformed*. Norton.

Tasker, F., & Golombok, S. (2005). Adults raised as children in lesbian families. *American Journal of Orthopsychiatry, 65*(2), 203–215. https://doi.org/10.1037/h0079615

Trub, L., Quinlan, E., Starks T. J., & Rosenthal, L. (2017). Discrimination, internalized homonegativity, and attitudes toward children of same-sex parents: Can secure attachment buffer against stigma internalization? *Family Process, 56*(3), 701–715. https://doi.org/10.1111/famp.12255

U.S. Census Bureau. (2014). *Characteristics of same-sex households: 2013.* https://www.census.gov/content/dam/Census/library/workingpapers/2016/demo/finalpresentation.pdf

U.S. Transgender Survey Report. (2015). http://www.ustranssurvey.org/reports

Walker, J. J., & Longmire-Avital, B. (2013). The impact of religious faith and internalized homonegativity on resiliency for black lesbian, gay, and bisexual emerging adults. *Developmental Psychology, 49*(9), 1723–1731. https://doi.org.pnw.idm.oclc.org/10.1037/a0031059

White, T., & Ettner, R. (2004). Disclosure, risks and protective factors for children whose parents are undergoing a gender transition. *Journal of Gay & Lesbian Psychotherapy, 8*(1–2), 129–145. https://doi.org/10.1080/19359705.2004.9962371

Taylor & Francis
Taylor & Francis Group
http://taylorandfrancis.com

14
Affirming Queerness
Raising Happy, Healthy Children

REBECCA HARVEY, PAUL D. LEVATINO, JONATHAN RUIZ, and LINDA STONE FISH

We aim, in this chapter, to detail our affirmative therapeutic approach to family therapy which supports families to raise happy, healthy, queer[1] children (Stone Fish & Harvey, 2005). Affirmative therapy (e.g., Bigner & Wetchler, 2012; Hudak & Giammattei, 2014; Stone Fish & Harvey, 2005) is an emerging and evolving practice that is being learned often on the fly by those of us teaching, practicing, and writing about it. As family therapists, our work is heavily based on principles grounded in systems theory. But the field of family therapy has been limited by systems theory's "ethnocentrism" (Green, 2007) where the experience of the privileged majority (e.g., white, straight, cisgender, wealthy) is idealized, over-simplified, and amplified, becoming the standard by which minority identities and experiences are measured. Green (2007) writes:

> From this majority perspective, minority group phenomena stand out either as "exotic" or "problematic" and need to be explained, whereas majority group phenomenon blend in as "normal" and need no further explanation.
>
> *(p. 119)*

This fundamental bias has constrained family therapists from connecting the dots between how injustice at the cultural level manifests itself in micro-interactions in families (Giammattei & Green, 2012; Harvey et al., 2020; Hudak & Giammattei, 2014). This limits therapists' ability to support clients in lessening the impact of domination in their day-to-day lives and interferes with family therapists' ability to assist families in raising happy, healthy, and well-supported queer children (Harvey, 2012).

Queer theorists (Butler, 1993; Sedgwick, 1993; Spargo, 1999) have subverted traditional notions of gender binaries and heteronormativity and helped us understand queer identities as *interesting*, *necessary*, and *precious*. We believe affirmative family therapists must take this stance as we navigate our roles as clinicians, supervisors, and teachers of the subject:

> Being queer is not merely an issue of gender identity or sexual orientation. Being queer is also about recognizing the ways that one represents otherness, the unexplored, or the

[1] We intentionally use the word "queer" when writing and supervising to describe non-heterosexual and gender non-binary experience and identity. Informed by queer theory, we choose this in order to underscore the important differences that evolve out of non-binary and non-heterosexual experiences and lives. Our stance is that these differences in point of view, expression, creativity, role flexibility, and much more are crucial and valuable. As clinicians and supervisors, we encourage clients and trainees to assume that these "gifts of queerness" (Stone Fish & Harvey, 2005) are present and to practice unearthing them. The term "queer" lends itself to ambiguity, fluidity, and the motion of development. We are careful in clinical work to encourage individuals to define and redefine themselves as often as they like using terms that make the most sense to them.

DOI: 10.4324/9780429274626-18

> disallowed, and then, despite prejudice and injustice, insisting again and again that one belongs and that one is gifted, not in spite of these queer differences but because of them.
>
> *(Stone Fish & Harvey, 2005, p. 4)*

We start by proposing three elements crucial to affirmative queer therapy. First, one must question heteronormativity and essentialist notions about gender, desire, and sexuality. This requires rigor and bravery on the part of the therapist, supervisor, or supervisee as these elements are the building blocks of our most basic assumptions including our own personal identities and dearly held beliefs about human nature and relationships. Next, one must understand the intersectional nature of oppressed social identities. Intrinsic biases including patriarchy, misogyny, racism, classism, and heterosexism chaperone one another (Johnson & Lemaster, 2020). The experiences of gender, race, class, and sexuality are embedded within one another and policed by the power differentials that are alive within all human systems including family systems and the therapy room itself. For affirmative family therapists, this means we must become adept at discerning how these culturally imbued power differentials are experienced, integrated, and expressed in micro-interactions within relationships. Third, it is essential that an affirmative therapist believe in and identify the gifts of resilience that LGBTQ people have honed over years of navigating unique intersections of oppressed identities. With the gifts of resilience identified, the affirmative therapist's job turns to assisting the client system in claiming and integrating these unrecognized gifts into a productive operating gestalt.

Historical Context

Psychological study of lesbian, gay, and bisexual (LGB) identity has gone through dramatic shifts in the last 50 years. Traditionally, it was assumed that *homosexual* behavior was a mental illness, and researchers were interested in exploring its etiology (Beatty, 1999; Roesler & Deisher, 1972; Strommen, 1989). As that view ebbed, homosexuality was taken out of the DSM, focus on sexual behavior shifted to an emphasis on sexual identity, and research transitioned to explore how queer people learned to manage minority stress and navigate the complexities of socially stigmatized identities. The burden continued to be placed on the client to accommodate one's self to the operating paradigms and expectations of heterosexual culture when crafting identity.

Then and now the developmental task for sexual and gender minorities is to "solidify a stable, healthy, and integrated "sense of self" in family, community, and societal environments which are largely hostile to their existence" (Harvey, 2012, p. 12). Early research on queer identity focused almost exclusively on sexual orientation and relied almost entirely on the recollections of adult, white, European American men (usually middle to upper class) recalling their coming out process. This led to the development of several stage theory models which identified important milestones non-heterosexual individuals negotiated in a series of successive stages that ultimately led toward an integrated identity as a gay or lesbian person. Originally, the stage models were an advancement, usefully conceptualizing sexual development from within a somewhat less pathologizing framework. Yet stage model theories are deeply flawed (Green, 2000; Harvey et al., 2020; Savin-Williams, 2001), theorizing about sexual identity though the singular lens of a white, male, urban, and middle/upper class perspective. As such this early research often claimed knowledge about "LGBTQ experience" ignoring the experiences of other queer identities such as transgender youth, youth of color, or other minoritized individuals. Youth are developing more fluid, complicated, and overlapping gender and sexual identities (Diamond, 2012; Dube, 2000) and are disclosing these identities at ages younger than previous generations (Russell & Fish, 2016; Ryan, 2014). What once was a more internal, individual process of identity development has become more overtly a family systems process, begun while youth are still

living at home (Stone Fish & Harvey, 2005). Stage models struggle to keep pace as clinicians work to support people with overlapping developmental trajectories that include intersectional considerations such as race, class, gender, sexual orientation, religion, and sexual expression.

The terms associated with queer identities have strained to keep up with a gender spectrum which continues to expand well beyond a binary. Gender expansion makes traditional labels such as male, female, straight, lesbian, gay, and bisexual seem overly simplistic and anachronistic. Clients are exploring more complex intersectional identities outside the traditional binaries of gender and sexuality (Diamond, 2012; Green, 2000), identities that are increasingly contingent on personal interpretations and meanings. Affirmative family therapists need words that communicate common understandings and shared meanings, but language has struggled to keep pace because basic (English) terminology is rooted in binaries that no longer capture the lived experiences of human beings. Lastly, affirmative family therapists need a construct that embraces the essential gifts queer individuals bring to themselves and communities rather than measuring their lives and relationships in comparison to idealized heterosexual, white, cisgender expectations.

Minority Stress and LGBTQ Youth

Most LGBTQ youth, like all youth, are generally healthy and well adjusted (Adelson et al., 2016). However, despite increased acceptance of LGBTQ identities in the larger culture, queer youth continue to be at elevated risks for a variety of health challenges (Russell & Fish, 2016). Historically these elevated risks were viewed as entirely within queer identities which were seen as intrinsically pathological. But within the last 40 years research has moved toward understanding cultural stigma as the main source. *Minority stress* theory asserts:

> …sexual minorities experience distinct, chronic stressors related to their stigmatized identities, including victimization, prejudice, and discrimination. These distinct experiences, in addition to everyday or universal stressors, disproportionately compromise the mental health of and well-being of LGBT people.
>
> *(Russell & Fish, 2016, pp. 468–469)*

Minority stress is associated with significant and lasting health disparities between LGBTQ youth and heterosexual youth (Adelson et al., 2016). This includes increased risk for substance use and abuse (Marshal et al., 2008), mental health diagnoses including depression and anxiety (Liu & Mustanski, 2012; Needham, 2012), eating disorders (Austin et al., 2013), suicidality (Marshal et al., 2011), and higher rates of pregnancy and sexually transmitted infections including HIV (Wood et al., 2016).

School Concerns The school community, the environment in which many youth spend most of their waking hours, has a direct and immediate impact on queer youth. The Gay Lesbian and Straight Education Network (GLSEN) has worked on protecting LGBTQ youth in schools for decades. Their 2017 survey of 23,000 ethnically and culturally diverse students from all 50 states found that almost 60% of LGBTQ students felt unsafe at school because of their sexual orientation, whereas 44.6% felt unsafe because of their gender expression. Nearly 84% of LGBTQ students experienced bullying and/or harassment at school. Of those 55.3% did not report it to any authority because most often they did not believe it would effectively accomplish anything or because they were afraid of retribution. Nearly 35% of LGBTQ students missed at least one day of school because they felt unsafe or uncomfortable (Kosciw et al., 2017). Their research found that LGBTQ students were also bullied or harassed at school based on other characteristics—26.9% based on religion, 25.6% based on actual or perceived race or ethnicity, and 25.5%

based on actual or perceived disability. Zeeman, Aranda, Sherriff, and Cocking (2017) found that specifically transgender or gender expansive youth resiliently learned to navigate hostile school and community environments and that affirming school nurses, teachers, and therapists were in important positions to support this resilience.

Homelessness There are still an alarming number of queer youth who are kicked out of their homes after parents discover their child's identity (Whitbeck et al., 2016). Research indicates that somewhere between 20% and 40% of all homeless youth are LGBTQ while 34% of homeless youth identify as lesbian, gay, bisexual, or "something else," and among these youth the most common reason given for initially becoming homeless was being told to leave by a parent or guardian (Whitbeck et al., 2016).

While all youth face developmental challenges, queer youth face particular challenges to developing a healthy sense of self. Research indicates that LGBTQ youth, especially those who are gender expansive, are more likely than heterosexual youth to experience multiple adverse childhood experiences of abuse and neglect (Baams, 2018; Friedman et al., 2011). Experiences at school and homelessness are often a major part of a cycle of victimization. It is this *polyvictimization* which is the underlying source of lasting health disparities that continue into adulthood.

Minority stress is compounded when a youth is a member of additional minoritized groups according to ethnicity, race, immigration status, class, religion, or varying ability (McConnell et al., 2018). Conceptualizations about the health and well-being of LGBTQ youth must account for complex intersections of experience. Mustanski et al. (2010) found that elevated prevalence of mental health disorders among LGBTQ youth was similar to the elevated rates found among minoritized urban youth. McConnell et al. (2018) found that white men who identified as sexual minorities consistently found respite from minority stress within LGBTQ community connections. This respite was much less likely for sexual minoritized men of color, who reported the highest racial and ethnic stigma in LGBTQ spaces of any racial groups. Similarly, Legate et al. (2012) raise questions about when coming out to family is supportive or not.

When imagining and developing mental health interventions, it is important to remember that what supports one youth in their unique intersections might exacerbate difficulties for another. Minority stress is experienced at multiple levels including (a) the structural level with policies, procedures, and practices which intentionally or unintentionally discriminate; (b) the interpersonal level when youth experience victimization or rejection; and (c) within the individual as happens when queer youth internalize negative messages they receive about themselves (Hatzenbuehler & Pachankis, 2016).

Role of Families

Minority stress leaves queer youth more vulnerable to chronic experiences of polyvictimization including abuse, neglect, and discrimination in multiple contexts and across levels of interaction from large scale to the very intimate. Additionally, as cultural acceptance increases, young people are disclosing queer identities at younger and younger ages (Russell & Fish, 2016; Ryan, 2014). This places particular burdens on family systems since repeated studies show that supportive families optimize protective factors and help youth manage minority stress (Heatherington & Lavner, 2008; Katz-Wise et al., 2016; Ryan, 2014; Ryan et al., 2010). Families play a pivotal role in positively and negatively mitigating the health risks of LGBTQ youth (Ryan, 2014) but they do so differently based on unique intersections of culture and social identity. But, as Russell and Fish (2016) point out, we are only at the beginning of conceptualizing the unique impact of various intersectional variables on healthy queer development, "patterns of mental health may vary across not only sexual and gender identities, but also across racial and ethnic, cultural, and social class identities as well" (p. 466).

Savin-Williams (2001) has proposed the concept of differential developmental trajectories for queer youth, meaning that the developmental process that sexual minority youth go through is both similar to and different from the developmental process heterosexual youth undergo—and that it is both similar to and different from other queer youth processes. All youth face developmental tasks. Queer youth face special tasks and challenges as they come to recognize they are not heterosexual or not cisgender. They must then learn how to negotiate coming out to others which prompts them to deal with the unique minority stress of the social circles integral to their lives. Families often lead with the best of intentions but have difficulty helping their queer children navigate childhood and adolescence because they have no road maps and are bound up in their own heteronormativity. Schools and religious communities are often caught off guard, or outright rejecting, leaving youth without adult mentors to guide and support them. In the helping professions, there has been a lack of services for LGBTQ youth which include their families because only the most progressive families were considered capable of being "supportive" (Ryan, 2014). Yet the culture has shifted dramatically, and it is a mistake to underestimate a family's ability to support children. Ryan showed that parents who engage in rejecting behaviors such as putting pressure on their children to identify as cisgender and heterosexual often do so with intentions of protecting their children. However, these actions lead to increased susceptibility to depression, substance abuse, unprotected sexual encounters, and suicidal ideation and attempts. For family therapists working with queer youth and their families, it is important to increase expressions of love and acceptance while decreasing expressions of rejection and hostility (Ryan et al., 2010).

While research confirms that disclosure to family members, particularly parents, can be an important psychological experience and developmental milestone for queer youth, it contains both risks and rewards (Rosario & Schrimshaw, 2014; Ryan, 2014) and should not be considered a universal goal for all LGBTQ people (Green, 2000). For many LGBTQ youth, disclosure represents a major opportunity to be meaningfully seen and more accurately known by their families who otherwise assume them to be cisgender and heterosexual. However, the benefits of disclosure are highly dependent on family and community context (Fields et al., 2016; Green, 2000). It is important for the clinician to consider the likelihood of a positive response from the recipient of a coming out disclosure, and the capacity and resources of a young person to absorb a negative response should a rejection occur. Disclosing while living at home can be a catalyst for some youth to feel more connected to their families (Beals & Peplau, 2006; Savin-Williams & Ream, 2003). For a variety of reasons, youth may find that disclosure is not important nor desired, not the least of which is that it could be unsafe precisely because living at home puts them in vulnerable positions should the family have a negative reaction.

LGBTQ youth of color must simultaneously navigate racial identity development with sexual and gender identity development within environments that contain both racist and heteronormative cultural expectations. Family, community, and religious organizations are often vital sources of support and security for youth of color providing them protection and guidance as they negotiate interpersonal and structural racism (Fields et al., 2016). However, being open about their LGBTQ identity can result in alienation from these resources and the loss of important protective family and community connections whom they rely on to mitigate the daily experience of racism (Fields et al., 2012). Researchers have found that queer youth of color are less likely to come out to their families than white youth and face conflicts between strong familial/cultural expectations and sexual minority identity (Dube & Savin-Williams, 1999; Fields et al., 2016; Maguen et al., 2002). As Fields et al. (2016) note:

> In this context, nondisclosure of sexuality may be protective and adaptive by allowing the individual to preserve important social supports. However, as sexual and racial minority youth, the internal conflict some young men wage between cultural

> expectations and their sexuality may further isolate them at a time when interpersonal attachments are important.
>
> *(p. 1094)*

We are only beginning our understanding of the complex interplay of identity development in the context of various intersectional variables such as race, ethnicity, class, sexuality, and religious affiliations. Heatherington and Lavner (2008) advise clinicians that certain individuals will have unique needs for support based on intersectional variables. A comprehensive consideration of variables such as race and queer identity is critical when providing affirmative therapy to queer youth.

Recommendations for Assessment

There are multiple individual, family, and larger cultural variables that meaningfully influence how a family handles raising a queer child. We believe that everyone who comes to therapy is organized by unspoken beliefs impacted and organized by systems of power. These beliefs include expectations related to race, gender, sexuality, heterosexism, and homophobia. Harvey and Stone Fish (2015) assert that it is not enough to create a therapeutic space that contains a family without also opening space for new ways to think about these organizing principles, "Effective treatment must be crafted to honor the sociocultural intersections of queer youth's lives and the singular way these individual traits, family dynamics, and cultural junctions produce unique constraints of oppression" (p. 400). Treatment ideology and thorough assessment go hand in hand. First, at the individual level it is important to assess the developmental trajectory of queer youth. All youth face similar developmental tasks, and queer youth face unique challenges to these tasks compared to non-queer counterparts. We utilize Savin-Williams's (2001) concept of differential developmental trajectories as a helpful assessment tool in seeking to understand both the similarities and difference between our client and all youth.

What follows is a list of questions we use to assess the unique developmental processes of the family systems we are working in. We may or may not directly ask these questions of clients.

Though this list is not exhaustive, we use it as a guide to gather information:

1. *Intersectional Identities*: What intersecting identities are in play for this young person? What have their experiences been with discrimination, microaggressions, and stigma? How does race/ethnicity and culture influence this person and their family system's beliefs about gender and sexuality? What people, relationships, contexts, and experiences might be threatened or lost to this youth as they gain a healthier, integrated sense of queer identity? What gains might there be in developing a queer identity? Which important people and contexts would their minority sexual or gender identity be most difficult for and why?
2. *Gender/Sexual Identity Development*: How is the young person doing at developing and integrating their gender identity, however it is they define this? How do they handle school? What interests them and how do they see themselves in the world? What is their definition of their gender? How do they understand where they fit in a world where binary categories are the norm? How do they feel about their bodies? What kind of romantic/sexual relationships are they interested in? Are there other individual variables that get in the way of their competence and agency that we should know about?
3. *Peer Relationships*: How is their sexual or gender identity affecting their ability to connect with peers—young men, women, and non-binary people their age? How diverse are these peer relationships? Do they have intimate friendships? Have they been able to talk with any peers about their sexual or gender identity? Are they sexually active,

and if so are they able to discern differences between sexual intimacy and emotional intimacy? Are they emotionally secure or vulnerable in regard to their body image?

4. *Family Relationships*: How is love and support expressed in this family system? How are children fostered to be connected as well as increasingly independent? What specific things would youth and/or parents like to see as evidence of increased independence? How does sexual and/or gender identity affect their ability to establish independence in the family? In other words, are youth feeling cut off and disengaged from family and therefore more likely to act independently even when they should reach out for support or help? Or are they feeling embattled and afraid and therefore less likely to try to establish independence from family because the family system is shielding them from larger pressures and stigma? How are intersectional identities (such as ethnicity, race, religion, class) present and influencing relational processes?
5. *Social Stigma and Support*: How are they managing social stigma? What is their experience of bullying and/or harassment in school, and how is it the same or different from the experience of other youth? How are intersectional identities present and influencing relational processes? How do they handle harassment, and how do they handle being different? How do they personally experience the current political state of the country? Who provides acknowledgment and support of their experience?

Second, at the familial level, it is important to assess family strengths and weaknesses that work for and against nurturing environments for sexual minority youth. Although we know how important it is for youth to be known and valued by their families, we are also aware of how difficult it is for some families to accept minority sexual or gender identities. Therefore, disclosure is a risky prospect because some families truly lack the capacity to be protective or supportive and will punish queer youth for their sexual identity. Important questions include: who knows and how much do they know? How did disclosure occur and how was it reacted to? These variables play into how much support families are capable of offering youth and must be carefully monitored as therapy progresses. Assessment and intervention work together in family therapy, a process we demonstrate further in the next section.

Third, we are actively assessing cultural variables and their influence on families and on youth. How much support is in the local community? Are there openly LGBTQ adults living and working there? Is there evidence of affirmative resources? What is the local school district like in regard to providing a queer affirmative environment? What, if any, LGBTQ resources are available? Are there open discussions and trainings regarding diversity issues, especially regarding queer identity?

Our Model of Family Therapy

Our four-stage model works to foster family systems to truly see and know their LGBTQ children, appreciating their unique struggles and unique gifts. The model proceeds as follows: Stage (1) creating refuge from stigma, bias, and microaggressions; Stage (2) fostering difficult dialogues; Stage (3) nurturing queerness; and Stage (4) encouraging transformation.

Bianca is a 15-year-old who identifies herself as a genderqueer, pansexual Puerto Rican and African American youth who uses she/her pronouns. She was referred to therapy due to family conflict, school issues, and behavioral problems. Her father (African American) passed away due to a heart attack when she was 12 and her mother Alexis (age 39, Puerto Rican and African American) then married her stepfather David (age 42, Irish/Italian American) when she turned 13. David works in I.T. and Alexis works as a real estate agent. Bianca grew up in a large city in the northeast United States and the family moved to a home in the suburbs when she turned 15.

Bianca is an only child and has experienced a "close relationship" with her mother until her second year of high school. Since then, the two often get into screaming matches over Bianca's

rebellious behavior and dress. Bianca identifies as genderqueer and regularly dresses in clothing that is more masculine in nature. Her mother is confused by the labels Bianca uses to describe herself and wants her daughter to look, act, and dress "more traditionally feminine." The school reports Bianca has a significant number of absences. This confuses Alexis and David because they drop her off at school every morning.

Two weeks prior to starting family therapy, Bianca snuck out of her bedroom in the middle of the night and met up with a group of friends in a nearby park. The police found the group and returned Bianca home. Alexis believes the behavioral and identity changes began when Bianca met Sasha, a girl at school. There have been conversations between David and Alexis about sending Bianca to a boarding school in order to "straighten her out." David refuses to attend family therapy reporting that Bianca is "Alexis' problem." During the intake phone call, Alexis reports being desperate for things to change and explained that her marriage is being negatively affected by Bianca's behavior.

The therapist for the family is Lucas, a 32-year-old Latino heterosexual cisgender male who is married and the father of three. He has experience working with youth with behavioral issues; however, he has only worked with a handful of LGBTQ youth.

Creating Refuge

Affirmative family therapy must help families create refuge from the negative messages, grounded in heteronormativity about the LGBTQ identities and lives. Whenever a family is referred to therapy for a particular problem with a youth in the family, we first set up separate meetings with the youth and parents (Wachtel, 1994) to gather a detailed assessment of their child's developmental history. As we gather information, we listen for stigmatizing messages regarding non-traditional gender roles and sexual orientations. Meanwhile, we pay attention to the intersections between these messages and attitudes about class, ethnicity, race, and religion. We work toward creating ground rules for family sessions that allow us to connect and address these intersections effectively. For example,

Alexis: (A well-dressed woman whose appearance suggests careful attention to detail and traditional feminine gender roles) My daughter has changed. I'm at my wits end with this child. And I'm sure it's all because of those FRIENDS she's always hanging around with. Now, my husband and I fighting. You are the last chance to fix her. I'm sorry, but I am not going to let her acting out ruin my marriage.

Therapist: You sound so worried, for everyone—your daughter, your husband, your marriage. That is a lot of worry to carry around.

Alexis: Yes, and the last two years have been awful. Maybe the worst since my first husband died.

Therapist: I notice your current husband did not come with you today.

Alexis: Yes, he is so fed up with her and with me. Ah……he's a good man but he doesn't have other children. It's all so hard for him to understand.

Therapist: I am so sorry that this has been so hard. It sounds like your multiple worries are piling up and affecting one another.

Alexis: What do you mean?

Therapist: Well, I mean that your worry for your marriage is affecting how you see and interact with your daughter. And your worry for your daughter is affecting how you see and interact with your husband. Sounds like the same might be true for your husband and daughter as well. You are all struggling to connect with one another and that is hard on everyone.

Alexis: I'm not sure he'd agree.

Therapist: Well, his feelings for whatever is happening with your daughter are clearly affecting his interactions with you. I think I could help. How might we make it easier for him to join us?

In the early stage of the model, we begin by creating refuge from stigma, bias, and microaggressions that are fostered by societal expectations such as heteronormativity, cisgender-normativity, and white supremacy. Here the therapist is creating refuge by deeply listening to Alexis who is often confused, unsure, and afraid of being blamed. Sensing that Alexis' concerns for both her child and her marriage are overwhelming her, the therapist intervened by creating a more systemic picture, highlighting how everyone is affecting and being affected by the family dynamics. The therapist is also encouraging Alexis to begin to see how her worry and fears make parenting challenging (Stone Fish & Harvey, 2005). We use this time to connect and build relationships with clients in order to assess their capacity to nurture themselves and their sexual minority youth. We want to understand what parents have been through, how they have tried, what seemed to work, and what is simply not working.

Alexis: (becoming a bit teary eyed.) I just don't know what to do anymore. I have worked so hard to improve our lives, but does she get that?

Therapist: So you're feeling underappreciated. I'm a parent also, I can relate. Maybe you can tell me a bit about when these problems began?

Alexis: Probably about a year ago. We moved to a nicer neighborhood and a better school district. I know it was hard on her. But it was to help her. All she did was complain about the house, the neighborhood, the move, the school. My husband felt unappreciated, pissed-off, and hurt. We had both worked hard to give her better than we had coming up.

Therapist: And how were things before that?

Alexis: Fine! We used to go out on mother daughter dates, get our nails done, go shopping. We were like best friends. She would tell me everything. In the past year she just began pulling away and is always sneaking around.

Therapist: That sounds really heartbreaking. You know…alot of teenagers don't want to spend time with their parents, so you've done a great job at raising a normal teenager. And it still hurts. How are you taking care of this hurt?

Alexis: Well, I'm trying to get through to her. I mean I didn't really want to hang out with my parents at her age, but I wouldn't dare talk to them the way she talks to me. The attitude she gives me sometimes…and the secrets… (she shakes her head in disapproval). A week or two ago she snuck out of the house in the middle of the night! Maybe I'm just not strict enough with her. I just don't know what else to change. I don't leave her alone AT ALL. God forbid she ends up pregnant or starts doing drugs or something. She's already having trouble at school.

Therapist: Wow! What strikes me is how deeply you are feeling. And how you are feeling so many different things. You love and care for your child, and you are really missing her. And you are worried about her and trying to protect her. At the same time, she is doing great at her job of growing up and being a teenager, exploring and finding herself and her identity.

Creating refuge from heteronormativity is an ongoing part of this model and our therapeutic stance. Therapists create refuge in a nuanced manner, mindful of intersectional variables.

One way to do this is to ask questions about inadvertent parent statements around gender and sexual identity. An example of this is outlined in the following case dialogue:

Alexis: I am frightened for Bianca. She was a sweet child who was always happy and pleasant. But now, she is always angry and fighting—acting like some thug off the streets. You'd hardly know I have a daughter considering how she acts and how she looks.

Therapist: What are you frightened will happen?

Alexis: Listen, she is a Black girl acting all thug in this world. She has to watch herself. She has to act and dress a certain way. The world isn't going to help her do it.

Therapist: That sounds like so much pressure. How have you handled this kind of oppression in your own life?

Alexis: Well, not by being a thug and dressing like a man. I can tell you that. I learned to dress well, act like a proper woman *and* stand up strong for myself *correctly* as a Black woman and as an immigrant in this world.

Therapist: I am thinking about how unfair all that pressure is to be *correct*, to be the *right* way an immigrant or a Black woman is supposed to be. Whatever that is. I'm guessing Bianca is also trying to figure that out now. And she has you as a role model to help guide her.

Alexis: Exactly*! But that girl's not listening.*

Therapist: Well maybe in some ways she is. I haven't met her, but she sounds strong and confident and bold. That seems like it comes from you, no?

Alexis: Sure, but she's not bold like I am. She is different from me.

Therapist: Exactly so. You are both under pressure trying to survive in a world that undermines Black women. You found your way through. She's trying to find her own. And it's getting between you rather than bringing you and Bianca together. I wonder if that's fair and how we might help Bianca as she finds her own way through those challenges.

In a subsequent session, Lucas meets with Bianca separately to discuss her experience and concerns and to build a therapeutic alliance. When Bianca arrives, she makes no eye contact and rolls her eyes when Lucas greets her. She generally acts annoyed. The process of creating refuge with Bianca begins:

Therapist: Hi, Bianca, I'm Lucas. I had a chance to meet with your Mom earlier this week. I'm looking forward to talking with you, but I sense you are not that happy to be here.

Bianca: It's fine. (She is sitting closed off and her tone conveys annoyance.)

Therapist: I wonder what you might like to talk about?

Bianca: Nothing.

Therapist: Hmmm, so it seems like you might be feeling forced to be here. That must be really uncomfortable.

Bianca: Yeah, well whatever. It is not fun to be me right now.

Therapist: Well, do you have to be here?

Bianca: I don't know, you tell me.

Therapist: Well, my understanding from your mom is that there has been a lot of fighting between you and her. I really want to hear from you because I sense you have your own story to tell. I know you really matter to your Mom. I also think it's important for you to know that your Mom and I have agreed that I will not share with her what you and I discuss together, unless, like we discussed earlier, it's a matter of safety. And I won't be sharing with you what she has said to me either. Though I will encourage you to share with each other.

Here Lucas is creating space for hearing Bianca's story in a non-pressured way and empowering her to tell it when (and if) she chooses to. This is sometimes tricky with parents who are very worried for their children. They ask for immediate results and are impatient at a slow pace to initial treatment. We have found that with careful explanation and reassurance, parents can often successfully navigate this anxiety. Lucas creates a transparent environment here, explaining what will and what will not be shared of the session. He carefully explains this will apply to all participants in treatment. This is an important way to create refuge, establish trust in the therapeutic relationship, and establish faith in the treatment process.

As the session goes on, Lucas asks about Bianca's hobbies, favorite food, and favorite classes. Bianca appears determined to give as little information as possible, replying in one or two words and effectively shutting down the conversation.

Therapist: How about friends? Do you have someone special, a boyfriend, girlfriend, partner?
Bianca: (appearing a bit uneasy) No. I have Sasha and Jamie.
Therapist: Can you tell me more about them. Is Jamie a guy or girl?
Bianca: Neither…
Therapist: (Feeling a bit confused and embarrassed.) Oh? ok. (Lucas realizes that he unintentionally assumed a gender binary with his question)
Bianca: Damn! See that is the problem. Everyone sees Jamie as a girl or Bianca as a girl. Everybody always fitting us into boxes we didn't ask for. We don't fit that thing.
Therapist: You are right I made a lot of assumptions just then. Sounds like you are used to that happening. I am going to try and do better. I hope you will give me another chance.
Bianca: It is just like at school, filled with people all white, all acting a certain way. And we are the freaks.
Therapist: How is that experience for you to be in a mostly white school?
Bianca: It's annoying and I miss my old school. At least there it wasn't so preppy. Here, they tease me for how I dress and talk. They call me "heshe" because I dress like a guy. Sasha and Jamie are the only ones that get it.
Therapist: You ever tried telling the teacher about what's going on?
Bianca: Shit, they don't care. They already made up their mind about who is starting trouble. So sometimes I throw hands to get them to leave me alone.
Therapist: You mean fighting?
Bianca: Yeah. If I'm going to get in trouble anyway, I might as well get something out of it.
Therapist: It sounds like you have this reputation of being this "bad kid" to some people. Would you be interested in working with me to help change people's mind?
Bianca: I don't care what they think. I know who I am.
Therapist: Good! That's impressive to be able to stand up and realize you can't make everyone like you. You are not pizza (Bianca smiles). And I am also thinking that it sounds like a tough situation for anyone to be in. How do Sasha and Jamie handle this?
Bianca: Jamie is a bad ass. They have to be.
Therapist: Yes, it sounds like Jamie also feels different…minoritized by others and judged for it. Can you tell me more? What are you learning about the assumptions the world makes about you? What are you learning about yourself?

Creating refuge in affirmative therapy is accomplished by creating a therapeutic space that is curious about how clients experience power differences. In addition to sexuality and gender, this includes intersectional client dynamics such as race, class, immigration status, and ethnicity. Affirmative therapy uses curiosity to address and contain domination and to empower clients to create their own story of their lives or identity. Therapeutic refuge is an attempt to momentarily pause heteronormative assumptions, or at least acknowledge when this doesn't happen and attempt repair (as Lucas himself fell victim in the previous session's dialogue). When Lucas realized in session that he too had made assumptions about gender, he used this as an opportunity to acknowledge this and do better. This both helps to build trust and models relationality and flexibility. After acknowledging and recovering from this lapse, Lucas sees that Bianca has hidden resilience demonstrated by her insistence in authentic expression. Despite numerous affronts to Bianca's expression from family and peers, she insists on being and expressing herself. The affirmative therapist searches for and acknowledges these strengths.

Fostering Difficult Dialogues

Families who come to therapy concerned about a youth's behavior may or may not have talked directly about sexual identity. Comfort with the topic varies greatly within and between families. In some families, any discussion about sexual identity is fused with discomfort, often because the family merges sexual identity with sexual behavior. There is a wish to keep their children safe from the physical and/or emotional dangers that sexual activity can expose their child to, and such a conversation could be construed as advocating sexual behavior. In other families, this may be because the family is unwelcoming of conversations and topics that challenge traditional heteronormative and cisgender expectations. The parent may wish to keep their child safe from the emotional challenges and physical safety risks associated with non-traditional roles by attempting to shut down the conversation (and issue) completely. In families with conservative family values, these conversations may be considered taboo subjects that are not discussed. In other families, conversation flows freely between some members yet not among others. And in other families, there is a discussion but it is heated and raw, and hurt feelings compound a sense of distance and isolation.

In this stage of the model, fostering difficult dialogues, we begin to unpack imbedded biases that hinder growth and development. The session with Alexis, Bianca, and Lucas took place after four individual sessions:

Bianca: I was just talking about how you always want to control everything.
Alexis: I do not! I just want better for you!
Bianca: But you keep trying to tell me how I should talk and act.
Alexis: Do you know why? Because people will judge you and treat you badly as soon as you open your mouth and speak. You don't have to even do anything. A Black girl in the suburbs, they are always thinking something about us.
Bianca: I don't care.
Therapist: Well, what I'm hearing is that Alexis, you really worry about Bianca having to deal with the reality of racism out there in the world. You are trying to do your job as her Mother and protect her. Meanwhile, Bianca your realness is so admirable. It doesn't seem to faze you what others think about you. I wonder if you have ever experienced the negative pushback of that?
Bianca: What do you mean?
Therapist: Well, I think we are sort of talking about it now. It's great to be who you are, and I think your Mom brings up a valid point. People will talk and judge you for it. What I think will be important, is figuring out which people are going to matter.
Alexis: Exactly. I don't want her going to an interview speaking to a potential employer the way she would her friends.
Bianca: I wouldn't do that! I can be really professional if I need to. You raised me to know that! I just don't see why you care so much about what everyone thinks about you?
Therapist: Marvelous. Alexis, I am wondering if you see how well you have done at raising a strong independent child, who is coming to understand the world. I am curious about how much you talk about what it is like for both of you to be yourselves in a world that is racist and sexist?
Bianca I am wondering what you know about your mother's experiences as a Black woman in the world? And Alexis what you know about Bianca's experience in her body? Is that something you would both be open to talking about?

In the session portion above, Lucas is enlarging a small interaction to foster difficult dialogues. Like many parents, Alexis has expectations and anxieties of her own related to Bianca becoming productively employed. She brings these anxieties, her care and concern of Bianca into these

conversations. Similarly, Bianca has anxieties and concerns related to growing up, fitting in, and claiming her unique identity in the world at large. Family therapy provides an opportunity for family members to engage in conversations within therapeutic space with an affirmative guide. Often, difficult conversations become stalled at home because someone leaves the room, takes up too much space, stops listening, or is mean and lashes out.

Difficult dialogues, best facilitated by a seasoned family therapist, are interchanges in which families are coached to slowly move toward and into their differences rather than away from them. While avoiding painful conversations can momentarily reduce conflict, in the long term the consequences are evident. Conflict avoidance stalls relationship development, isolates family members from one another, and encourages problems to go underground.

Fostering difficult dialogues changes the dynamics in a relationship, so the people involved in these dialogues change. This change usually occurs in small steps, through ongoing interactions that become part of family communication patterns long after the therapy is terminated. The goal of fostering difficult dialogues is to help family members begin to practice handling differences in a way that humanizes those differences.

Difficult dialogues are more than "coming out" conversations. They are conversations likely to broaden and deepen family members' understanding of their own and other family members' thoughts, feelings, and expectations about sexual identity, gender, race, and most importantly about power. More than likely, before coming to therapy, family members have had conversations that have been uncomfortable at best and hostile at worst.

To facilitate difficult dialogue in the therapy office, the therapist must understand and hold onto three concepts all at once. First, parents and children come to this conversation in different positions. Parent-child hierarchy means that parents are responsible and more accountable than children, and that children crave and deserve to be loved, known, and accepted. Second, heteronormativity and heterosexism permeate everyone's positions but to varying degrees. Whereas heteronormativity and traditional gender roles may have been a refuge for Alexis providing comfort and a sense of belonging as a Black woman in a racist culture, Bianca experiences these same gender expectations as hurtful, offensive, and constraining. Third, individual and relational dynamics make many conversations difficult to have. Whereas Alexis intends to listen to Bianca and to be supportive, Bianca is relentlessly critical and blaming. Any indication to Alexis that she did something wrong as a parent results in instinctually taking a defensive position that ends her ability to actively listen, support, or effectively parent.

The therapist takes all these variables into consideration as they sit with the family and facilitate difficult dialogues. When Bianca says, "You never listen to me," and her Mother reacts by saying, "That's because you are always being disrespectful," it is up to the therapist to focus on what is important, which is helping Alexis be a little more curious as she creates protective but flexible boundaries and to help Bianca be a bit more open as she accepts some support.

A therapist facilitates this conversation by calmly and ardently remembering this goal and the multiple paths one might use to achieve it. Here is what the therapist could say at this point to help move the conversation forward into a difficult dialogue:

> Bianca, I know it is really hard for you to tell your mom about what is going on in your life. I think you may be worried she will be critical if you do. So instead of calmly talking about your life, you start the 'you-never-listen-to-me' conversation which never goes anywhere and just creates more problems for you. So, maybe you can start by picking one small thing you would be willing to tell your Mom about what is really going on for you.

Or the therapist could say,

> Alexis—so how Bianca talks to you prevents you from hearing her. I get that. It makes sense. I wonder if we could slow down a minute. I know, it doesn't seem like it, but I think you really matter to Bianca. There is a part of her that really wants to be heard and understood by you. I wonder, if we could start slowly and if you could let her know how much you really want to hear what she has to say?

Or the therapist could say instead,

> Bianca, I understand you don't think your Mom understands what is happening in your world or what you are going through. And she keeps trying to support and protect you in ways that don't feel supportive or protective of you. Would you be willing to tell your Mom one thing, something small she could do that would feel supportive and loving?

The goal is to keep the conversation moving forward and to help each member of the family be his or her best self in the conversation, and to show up as relationally supportive as possible. By fostering difficult dialogues, the therapist leads family members toward the third stage of our model, which is nurturing queerness. The research on queer youth supports what family therapists already know, namely, that supportive families help sexual minority youth navigate internalized homophobia and hostile environments. What has not yet been well researched is how sexual minority youth are conversely affecting family members perhaps by being more loving, accepting, flexible human beings (Harvey, 2012).

Nurturing Queerness

The process of integrating a queer identity in oneself or integrating a queer member of a family can become an enriching experience that offers unique gifts (Harvey, 2012; Harvey & Stone Fish, 2015). Some families begin to question the gender stereotyping that is the basis of their roles and expand their definition of gender, roles, and relationships. Others find that freeing themselves from rigid ways of thinking about gender and sexuality allows them more comfort to be who they want to be. Some individuals take up the cause of social justice for all, whereas others develop a newfound appreciation for their children and/or siblings. And, of course, some individuals do all of the above.

In the following session, Alexis, Bianca, and Lucas begin exploring the challenging issue of Bianca's dress in more typically masculine clothing, a subject that Alexis is extremely reactive toward.

Therapist: Alexis, I am curious about what is concerns you with the way Bianca dresses. You have brought that up a few times.
Alexis: Yes, she dresses like a boy. I miss the little girl and I am worried about her.
Bianca: Mom!!! Damn!!
Therapist: I wonder if I can stop you Bianca for just one moment. Alexis, what are you worried about, I wonder?
Bianca: Whatever.
Alexis: What are people going to think about her?! What are people going to think about us?! What is Dave going to do?
Therapist: You have mentioned Dave a few times, and it sounds like he has a commanding presence in your house. I wonder what that it is like for you, Alexis?
Alexis: Oh God, he has something to say every time Bianca comes downstairs dressed to go out. She goes to leave, and he starts in.
Therapist: I wonder who told you that you have to hear it? How did you take on that message?
Alexis: Well, it just happened that way.

Therapist: Maybe. What I think happens sometimes is that men in our culture are trained to offload parenting onto women, and that sometimes they hold value in fixing things. They get really frustrated when they can't easily fix things.

Alexis: Oh, I had that happen with Bianca's father, trust me!

Therapist: So you know Alexis, how sometimes it is hard to stand up for yourself with these powers pressing down on you. So here you have your daughter, who is standing up for herself. I wonder if you can see value in that? Some danger maybe, yes. There is danger and to deny that would make you a naïve parent. I wonder though, can you see value in that?

Alexis: Yes. I can.

Therapist: I can see value in it too. There are also challenges and maybe some dangers that would make me worried as a parent. But I worry Bianca only hears your worries and criticisms and does not get to hear the ways you are also proud of her strength.

Alexis: Definitely. That's true. I don't tell her that. I think she is too strong and she doesn't need to hear that from me.

Therapist: I think you have a strong child who also loves and respects you and does indeed need to know what you respect, admire, and love about her. You know at least in part what she is up against.

Bianca: Yeah Mom. What DO you respect about me?

Alexis: Well, I'm proud that you know who you are and that even when its hard or you feel pressure to be different, you can stay true to yourself.

In the session portion above, Lucas is working to highlight the range of emotions Alexis experiences when Bianca goes out dressed in typically assigned "masculine" clothing. Alexis is worried, she is anxious, and she is frustrated, *and* she is proud of Bianca for exercising her independence, individuality, and uniqueness—attributes dictated from and centered around her queer identity. By introducing Alexis to Bianca's ability to connect to and express herself and tying that to challenges Alexis herself experiences, Lucas begins to shift the dialogue, ever so subtly, from queer expression as a fear inducing, cringe worthy act, to a bold and commendable expression of personal identity, differentiation and affirmation. This has not significantly changed Bianca and Alexis' interactions with a lasting impact. That would be a naïve assumption. Yet, for a moment Alexis sees and acknowledges Bianca's gifts and strengths, while Bianca acknowledges receiving her mother's affirmation and acknowledgment. Nurturing queerness offers opportunities for caregivers to see themselves and queer youth through a new lens not so dominated by oppressive dynamics ensconced in patriarchy, heteronormativity, and racism.

Nurturing queerness is a therapeutic stance that is taken throughout therapy. We encourage parents to know their children just a little better, a little more flexibly. It does not have to be perfect. We believe that the more a child feels known and seen, the better a parent can protect and guide and the more likely a youth will accept this protection and guidance. When children are different from their parents, they often receive subtle, as well as not so subtle, pressure to conform. When they are unable to conform, they hide. When youth hide from their parents, they are less able to receive active parental support, love, but also limit setting. When youth hide their minority sexual identity from their parents, parents lose out on the opportunity to help youth set limits that are developmentally appropriate. When youth come out to their families while still living at home, they give their family members a gift. Part of nurturing queerness in families is helping parents acknowledge this and other gifts their queer youth have to offer. Thus, the youth are opening the family not only to diverse ways of being, but also to ways of communicating and keeping parents involved in parenting them.

Encouraging Transformation

We encourage some family members to become active in their own communities. We wonder how each family can uniquely and actively be supportive of their children. Some families take on the mission of social advocacy with fervency and others do not. We routinely ask clients and therapists we are mentoring how they might use their unique positions for example as heterosexuals, as churchgoers, as members of specific clubs, communities, and families, to lessen isolation for sexual minority youth and their families. For some individuals, using their power might mean thinking twice before they assume that someone is heterosexual. For others, it might mean asking questions in their church about how to be more respectful and inclusive of queer people. It might mean putting up a safe space sticker or a poster of an openly gay celebrity, or it might mean pointing out bias and discrimination against sexual minorities in their families or at their schools.

In the case vignette below, Alexis and Bianca are in the encouraging transformation phase with Lucas.

Therapist: I am wondering if you see how far you both have come in your work with one another.
Bianca: I don't notice anything different.
Alexis: Well I do, at least for me. And I am going to write that off as a typical teenage response and not get myself all bent out of shape about it.
Bianca: Kidding, Mom. *Kidding*!
Alexis: Well, do you think therapy is helping?
Bianca: I…guess…
Therapist: Alexis what has changed for you?
Bianca: Yeah, Mom. What's changed for you?
Alexis: Well before what just happened would have driven me crazy and I would have seen it as back talking she picked up from Sasha or Jamie…
Bianca: Mom! Damn!
Alexis: Let me finish. But now I get that is not tied into anything but Bianca being Bianca. And I can handle that. She's just growing up. (She turns and smiles at Bianca.)
Bianca: (mocking sincere niceness) Awww…
Alexis: And maybe I can handle that to. At least I think I can.
Bianca: I think you can. I am a good teacher.
Alexis: And do not forget where you got that from.
Bianca: I won't!
Alexis: No, I think we have changed. I mean it is not perfect. Sometimes Bianca and David get into it bad. I try to stay out and let them work it out. I am able to drop things and I tell him, "Hey, you should come to therapy with us. It helps me." But he won't. I think it is that guy thing, he likes to handle it all himself.
Therapist: I think when we started you really felt challenged when David and Bianca were arguing.
Alexis: Yup.
Bianca: And now you tell him where he can stick it sometimes.
Alexis: Sometimes. You two need to work it out. You will. We have three hardheaded people in our house.
Therapist: I am thinking about how you are both have come a long way. Bianca, I wonder if you see that.
Bianca: I guess.
Therapist: Alexis you seem more in control and less wavering in so many relationships. With your role as parent, with your role as wife, with your role as co-parent.

Bianca: She ain't taking shit from no one.
Alexis: I think I realized I was stronger than I might have thought.
Therapist: That sounds like some big learning.
Bianca: Yeah! Can we go now?

In the preceding vignette, Lucas, Alexis, and Bianca reflect on what has changed since starting family therapy. Alexis is better able to discern typical adolescent pushback and stay on track with her parenting goals (Stone Fish & Harvey, 2005) rather than let her anxiety ("I am losing my daughter") get in the way. Bianca does not specifically identify much change, yet subtly and definitely she recognizes a shift in the client system, and Bianca in turn is less reactive and argumentative. Subtle dynamics of gender, power, and gender roles are a part of the client system's vernacular because of the challenges they have faced together. Clearly, their life has its upcoming challenges. Yet in this moment we become aware that something has shifted.

Alexis expresses greater confidence in riding the uncertainty of the challenges of life itself. Exasperated and brought in through the subject of Bianca's queer identity, Bianca and Alexis have taken a journey and have experienced a small, albeit tangible transformation.

Conclusion

We have developed a treatment model that utilizes and builds upon family systems theory to best capture the resilience and strength of families of queer youth. This model builds upon existing queer theory regarding LGBTQ identity development to enhance our systemic focus and encourage greater growth and development within individuals and between family members. We begin by *creating refuge* from heteronormativity that still permeate the lives of many of the families with whom we meet. Creating refuge often includes providing space for family members to speak the biased, sometimes ugly ideas they have grown up believing about LGBQT people. Then we work toward *fostering difficult dialogues*. Out in the open these stereotypes can be challenged, personalized, and their effect on family relationships explored and neutralized. We *nurture queerness* so that families learn to embrace the positive elements of LGBTQ identity and encourage their children to stop hiding in order to allow parents to continue parenting. Finally, we *encourage transformation*, understanding that new ways of thinking about sexuality and gender are both threatening and freeing. We want to transform not just client family systems but also ourselves. Transformation requires that we fight the urge to separate ourselves from people who think differently. It is our hope to reach out even when it is difficult, to respectfully start and stay engaged in conversations with anyone who can also be respectfully engaged in conversation with us. It is our hope that conversations continue and that all dialogue is in the service of continuing to learn about differences rather than to change opinions. This would be a true gift to our human community.

References

Adelson, S. L., Stroeh, O. M., & Ng, Y. K. W. (2016). Development and mental health of lesbian, gay, bisexual, or transgender youth in pediatric practice. *Pediatric Clinics of North America, 63*(6), 971–983. https://doi.org/10.1016/j.pcl.2016.07.002.

Austin, S. B., Nelson, L. A., Birkett, M. A., Calzo, J. P., & Everett, B. (2013). Eating disorder symptoms and obesity at the intersections of gender, ethnicity, and sexual orientation in US high school students. *American Journal of Public Health, 103*(2), e16–e22. https://doi.org/10.2105/AJPH.2012.301150

Baams, L. (2018). Disparities for LGBTQ and gender nonconforming adolescents. *Pediatrics, 141*(5), e20173004. https://doi.org/10.1542/peds.2017-3004.

Beals, K. P., & Peplau, L. A. (2006). Disclosure patterns within social networks of gay men and lesbian women. *Journal of Homosexuality, 51*(2), 101–119. https://doi.org/10.1300/j082v51n02_06

Beatty, L. A. (1999). Identity development of homosexual youth and parental and familial influences on the coming out process. *Adolescence, 34*(135), 597–601.

Bigner, J. J., & Wetchler, J. L. (Eds.). (2012). *Handbook of LGBT-affirmative couple and family therapy.* Routledge.

Butler, J. (1993). *Bodies that matter: On the discursive limits of "sex."* Routledge. https://doi.org/10.4324/9780203828274

Diamond, L. M. (2012). Concepts of female sexual orientation. In C. J. Patterson & A. R. D'Augelli (Eds.), *Handbook of psychology and sexual orientation* (pp. 3–17). Oxford University Press. https://doi.org/10.1093/acprof:oso/9780199765218.003.0001

Dube, E. M. (2000). The role of sexual behavior in the identification process of gay and bisexual males. *Journal of Sex Research, 37*(2), 123–132. https://doi.org/10.1080/00224490009552029

Dube, E. M., & Savin-Williams, R. C. (1999). Sexual identity development among ethnic sexual minority male youths. *Developmental Psychology, 35*(6), 1389–1398. https://doi.org/10.1037/0012-1649.35.6.1389

Fields, E. L., Bogart, L. M., Smith, K. C., Malebranche, D. J., Ellen, J., & Schuster, M. A. (2012). HIV risk and perceptions of masculinity among young black men who have sex with men. *The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine, 50*(3), 296–303. https://doi.org/10.1016/j.jadohealth.2011.07.007

Fields, E. L., Morgan, A., & Sanders, R.A. (2016). The intersections of sociocultural factors and health related behavior in lesbian, gay, bisexual and transgender youth: Experience among young black gay males. *Pediatric Clinics of North America, 63*(6), 1091–1106. http://dx.doi.org/10.1016/j.pcl.2016.07.009

Friedman, M. S., Marshal, M. P., Guadamuz, T. E., Wei, C., Wong, C. F., Saewyc, E., & Stall, R. (2011). A meta-analysis of disparities in childhood sexual abuse, parental physical abuse, and peer victimization among sexual minority and sexual nonminority individuals. *American Journal of Public Health, 101*(8), 1481–1494. https://doi.org/10.2105/AJPH.2009.190009

Giammattei, S., & Green, R. J. (2012). LGBTQ couple and family therapy: History and future directions. In J. L. Wetchler & J. J. Bigner (Eds.), *Handbook of LGBT-affirmative couple and family therapy* (pp. 1–22). Routledge. https://doi.org/10.4324/9780203123614

Green, R. J. (2000). "Lesbians, gay men, and their parents": A critique of LaSala and the prevailing clinical wisdom. *Family Process, 39*(2), 257–266. https://doi.org/10.1111/j.1545-5300.2000.39208.x

Green, R. J. (2007). Gay and lesbian couples in therapy: A social justice perspective. In E. Aldarondo (Ed.), *Advancing social justice through clinical practice* (pp. 119–150). Lawrence Erlbaum Associates. https://doi.org/10.1080/08975350801905087

Harvey, R. G. (2012). Young people, sexual orientation, and resilience. In M. Unger (Ed.), *The social ecology of resilience: A handbook of theory and practice* (pp. 325–335). Springer. https://doi.org/10.1111/j.1939-0025.2010.01067.x

Harvey, R. G., & Stone Fish, L. (2015). Queer youth in family therapy. *Family Process, 54*(3), 396–417. https://doi.org/10.1111/famp.12170

Harvey, R. G., Stone Fish, L., & Levatino, P. (2020). Sexual identity development and heteronormativity. In K. S. Wampler & L. M. McWey (Eds.), *The handbook of systemic family therapy* (Vol. 2, pp. 541–569). Wiley. https://doi.org/10.1002/9781119438519.ch55

Hatzenbuehler, M. L., & Pachankis, J. E. (2016). Stigma and minority stress as social determinants of health among lesbian, gay, bisexual, and transgender youth: Research evidence and clinical implications. *Pediatric Clinics of North America, 63*(6), 985–997. https://doi.org/10.1016/j.pcl.2016.07.003

Heatherington, L., & Lavner, J. A. (2008). Coming to terms with coming out: Review and recommendations for family systems focused research. *Journal of Family Psychology, 22*(3), 329–343. https://doi.org/10.1037/0893-3200.22.3.329

Hudak, J., & Giammattei, S. V. (2014). *Doing family: Decentering heteronormativity in "marriage" and "family" therapy.* In T. Nelson & H. Winawer (Eds.), *AFTA Springer briefs in family therapy. Critical topics in family therapy: AFTA Monograph Series highlights* (pp. 105–115). Springer Science + Business Media. https://doi.org/10.1007/978-3-319-03248-1_12

Johnson, A., & Lemaster, B. (2020). Gender futurity, intersectional autoethnography: Embodied theorizing from the margins. Routledge. https://doi.org/10.4324/9781003043683-31

Katz-Wise, S., Rosario, M., & Tsappis, M. (2016). Lesbian, gay, bisexual, and transgender youth and family acceptance. *Pediatric Clinics of North America, 63*(6), 1011–1025. http://dx.doi.org/10.1016/j.pcl.2016.07.005

Kosciw, J., Greytak, E. A., Zongrone, A. D., Clark, C. M., & Truong, H. L. (2017). *The 2017 National School Climate Survey. Gay Lesbian Straight Education Network*. https://www.glsen.org/research/school-climate-survey.

Legate, N., Ryan, R.M., & Weinstein N. (2012). Is coming out always a "good thing"? Exploring the relations of autonomy support, outness, and wellness for lesbian, gay, and bisexual individuals. *Social Psychological and Personality Science, 3*(2), 145–152. https://doi.org/10.1177/1948550611411929

Liu, R. T., & Mustanski, B. (2012). Suicidal ideation and self-harm in lesbian, gay, bisexual, and transgender youth. *American Journal of Preventative Medicine, 42*(3), 221–228. https://doi.org/10.1016/j.amepre.2011.10.023.

Maguen, S., Floyd, F. J., Bakeman, R., & Armistead, L. (2002). Developmental milestones and disclosure of sexual orientation among gay, lesbian and bisexual youths. *Applied Developmental Psychology, 23*(2), 219–233. https://doi.org/10.1016/s0193-3973(02)00105-3

Marshal, M. P., Dietz, L. J., Friedman, M. S., Stall, R., Smith, H. A., McGinley, J., Thomas, B. C., Murray, P. J., D'Augelli, A. R., & Brent, D. A. (2011). Suicidality and depression disparities between sexual minority and heterosexual youth: A meta-analytic review. *The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine, 49*(2), 115–123. https://doi.org/10.1016/j.jadohealth.2011.02.005

Marshal, M. P., Friedman, M. S., Stall, R., King, K. M., Miles, J., Gold, M. A., Bukstein, O. G., & Morse, J. Q. (2008). Sexual orientation and adolescent substance use: A meta-analysis and methodological review. *Addiction, 103*(4), 546–556. https://doi.org/10.1111/j.1360-0443.2008.02149.x

McConnell, E. A., Janulis, P., Phillips, G. II, Truong, R., & Birkett, M. (2018). Multiple minority stress and LGBT community resilience among sexual minority men. *Psychology of Sexual Orientation and Gender Diversity, 5*(1), 1–12. https://doi.org/10.1037/sgd0000265

Mustanski, B. S., Garofalo, R., & Emerson, E. M. (2010). Mental health disorders, psychological distress, and suicidality in a diverse sample of lesbian, gay, bisexual, and transgender youths. *American Journal of Public Health, 100*(12), *2*426–2432. https://doi.org/10.2105/AJPH.2009.178319

Needham, B. L. (2012). Sexual attraction and trajectories of mental health and substance use during the transition from adolescence to adulthood. *Journal of Youth Adolescence, 41*(2), 179–190. https://doi.org/10.1007/s10964-011-9729-4

Roesler, T., & Deisher, R. W. (1972). Youth male homosexuality: Homosexual experience and the process of developing homosexual identity in males aged 16 to 22 years. *Journal of the American Medical Association, 219*(8), 1018–1023. https://doi.org/10.1001/jama.1972.03190340030006

Rosario M., & Schrimshaw, E. W. (2014). Theories and etiologies of sexual orientation. In D. L. Tolman & L. M. Diamond (Eds.), *APA handbook of sexuality and psychology* (pp. 555–596). American Psychological Association. https://doi.org/10.1037/14193-018

Russell, S. T., & Fish, J. N. (2016). Mental health in lesbian, gay, bisexual and transgender (LGBT) youth. *Annual Review of Clinical Psychology, 12*(1), 465–487. https://doi.org/10.1146/annurev-clinpsy-021815-093153

Ryan, C. (2014). Generating a revolution in prevention, wellness & care for LGBT children & youth. *Temple Political & Civil Rights Law Review, 23*(2), 331–344.

Ryan, C., Russell, S. T., Huebner, D., Diaz, R., & Sanchez, J. (2010). Family acceptance in adolescence and the health of LGBT young adults. *Journal of Child and Adolescent Psychiatric Nursing, 23*(4), 205–213. https://doi.org/10.1111/j.1744-6171.2010.00246.

Savin-Williams, R. C. (2001). *"Mom, dad, I'm gay."* American Psychological Association. https://doi.org/10.1037/10437-000

Savin-Williams, R. C., & Ream, G. L. (2003). Sex variations in the disclosure to parents of same-sex attractions. *Journal of Family Psychology, 17*(3), 429–438. https://doi.org/10.1037/0893-3200.17.3.429

Sedgwick, E. K. (1993). How to bring your kids up gay. In M. Warner (Ed.), *Fear of a queer planet: Queer politics and social theory* (pp. 69–81). University of Minneapolis Press. https://doi.org/10.2307/466296

Spargo, T. (1999). *Foucault and queer theory*. Totem Books.

Stone Fish, L., & Harvey, R. (2005). *Nurturing queer youth: Family therapy transformed.* Guilford Press.

Strommen, E. F. (1989). "You're a what?" Family member reactions to the disclosure of homosexuality. In F. W. Bozett (Ed.), *Homosexuality and the family* (pp. 37–58). Routledge. https://doi.org/10.4324/9781315864150-2

Wachtel, E. (1994). *Treating troubled children and their families.* Guilford Press.

Whitbeck, L., Lazoritz, M. W., Crawford, D., & Hautala, D. (2016). *Youth services bureau street outreach program: Data collection study final report.* Administration for Children and Families. https://www.acf.hhs.gov/media/2677

Wood, S. M., Salas-Humara, C., & Dowshe, N. L. (2016). Human immunodeficiency virus, other sexually transmitted infections, and sexual and reproductive health in lesbian, gay, bisexual, transgender youth. *Pediatric Clinics of North America, 63*(6), 1027–1055. https://doi.org/10.1016/j.pcl.2016.07.006

Zeeman, L., Aranda, K., Sherriff, N., & Cocking, C. (2017). Promoting resilience and emotional well-being of transgender young people: research at the intersections of gender and sexuality. *Journal of Youth Studies, 20*(3), 382–397. https://doi.org/10.1080/13676261.2016.1232481

Taylor & Francis
Taylor & Francis Group
http://taylorandfrancis.com

15

Gender Affirmative Therapy with Trans and Gender Expansive (TGE) Youth and Families

Listening to Youth and Thoughtfully Following Their Lead

DEBORAH COOLHART and TRISTAN K. MARTIN

When parents dream about their children's futures, they often think about successful careers, good health, happy marriages, and grandchildren. Part of this dream, though not often explicitly articulated, is that children will also assume society's majority gender roles. Although success and happiness are certainly possible for trans and gender expansive (TGE) children, parents may not initially believe this to be the case. Parents may believe that if their child is TGE then their life will be filled with pain, humiliation, harassment, isolation, discrimination, and potential violence. Thus, it is not unusual for parents to discourage gender expansive behavior, react negatively to their child's trans identity, and sometimes verbally and/or physically abuse their child because of gender expansiveness (Ehernsaft et al., 2018; Grossman et al., 2005). Additionally, parents adjusting to their child's TGE identity may experience feelings of anxiety, embarrassment, worry, anger, concern, denial, grief, shame, self-blame, disappointment, loss, confusion, and fear for their child's safety (Brill & Pepper, 2008; Coolhart et al., 2018; Lev, 2004). In the midst of navigating this complex experience, families often seek the assistance of family therapists to help regain feelings of stability and direction.

Often therapists themselves are anxious or uncertain when a TGE youth and their family walk into their practice, since most therapists do not receive adequate training to sensitively serve this population (Brill & Pepper, 2008; Coolhart et al., 2013; Lev, 2004). Therapists may also be worried about assisting youth and their families through social and medical gender transition. Therefore, the purpose of this chapter is to describe the gender shame (Stone Fish & Harvey, 2005) often experienced by TGE youth and provide a summary of our gender affirmative model for working with TGE youth and their families. We view our affirmative model through the lens of intersectionality; thus, we discuss some of the intersectional considerations with TGE youth and families. We also address the ways in which our own relational intersections as therapists (Addison & Coolhart, 2015) impact our work with this population, all of which are illustrated through a case example of our work with a family with a TGE youth.

"Gender Shame" for Youth Expressing Gender Expansiveness

Children sometimes begin to express a trans identity and/or gender expansiveness as early as when the child learns to speak (Brill & Pepper, 2008). During these preschool years, TGE children may verbally express their internal sense of gender, dress up in clothes that reflect their gender identity or expression, or try to change their name to reflect their gender identity. Often parents "correct" young children about gender and disapprove of cross-gender expressions. Therefore, children learn to bury their TGE identity and may feel shame about it (Brill & Pepper, 2008). Stone Fish and Harvey (2005) discuss *gender shame* happening in three stages. First, children are socialized to control their impulses that conflict with the cultural mandates of gender.

DOI: 10.4324/9780429274626-19

This may happen when a parent tells a child that they can't or shouldn't act on their impulses of gender expansive behavior. For example, a child assigned male at birth may be caught dressing in their mom's clothes and be punished for this behavior, thus learning that they are wrong for having this desire. The second stage in Stone Fish and Harvey's (2005) gender shame happens as humiliation is experienced when the child does not conform to gender mandates. For example, this humiliation for a child assigned male at birth happens when their cousins tease them about dressing in their mother's clothes, using hurtful gender slurs. This leads to the third stage of gender shame, where the child learns to silence those parts that are perceived as different.

This gender shame can be devastating for TGE youth because it often pushes their true sense of a gendered self deep within. In our clinical experience, TGE clients of all ages often recall specific painful childhood experiences in the gender shame process and then describe the difficult years that followed as they tried to hide who they really were. This internal dissonance causes psychological distress, often lending itself to the development of psychological symptoms such as rage, depression, low self-esteem, self-neglect, social anxiety, and self-harming behaviors (Brill & Pepper, 2008; Coolhart et al., 2008). Although the most common time for a TGE identity to develop is in early childhood, trans identities may instead emerge in prepubescent and adolescent years (Brill & Pepper, 2008). During this time, hormonal changes are happening in TGE youths' bodies, which may feel unnatural, leading to early feelings of body dysphoria because their bodies do not match their internal sense of gender. Thus, for many youth, gender shaming can start very early in life and for others, it may not be in full swing until adolescence.

It is also important to understand the impact of sex assigned at birth in the process of gender shaming (Coolhart & Mason, 2017). In the general culture of the United States, there is more flexibility for assigned females to express masculinity than there is for assigned males to express femininity. When children that we see as girls express themselves in ways that fit with what we generally perceive as masculine, we call them "tomboys." Being a tomboy is generally not seen as a bad thing, and while these children are still seen as girls, they are often relatively free to express their gender in ways that feel congruent for them. For assigned males, there is less flexibility to express femininity and these children often get called names, teased, punished, and sometimes abused for these feminine expressions, possibly leading to increased shame and internalized transphobia.

Gender Affirmative Therapy with TGE Youth and Their Families

Parents often seek family therapy after the discovery or disclosure of their child's gender expansiveness, and they come with a wide range of reactions. Some are fully supportive and just want to make sure they are making good choices with their child, while others are confused, uncomfortable, sad, angry, or even in disbelief. Family therapists working with TGE youth and their families have enormous potential to normalize, validate, and facilitate healing and growth in these families. At the core of a gender affirmative approach is that no gender identity nor expression is pathological (Keo-Meier & Ehrensaft, 2018), that they are all natural variations of humanity (Coolhart & Shipman, 2017), and that any pathology that is present is a result of transphobia, homophobia, and sexism, rather than a disturbance in the child (Coolhart, 2012; Hidalgo et al., 2013). Because our intention in this chapter is to give adequate space to discuss impacts of intersectionality, our gender affirmative approach is summarized here. For a deeper discussion of the interventions, please see Coolhart's other published work on this model (Coolhart, 2012, 2018, 2019; Coolhart & Shipman, 2017; Coolhart et al., 2013, 2018).

Assessing Parental Attunement and Deciding on the Structure of Sessions

One of the first tasks in work with these families is assessing parental attunement (Coolhart, 2012, 2018; Coolhart & Shipman, 2017). This can often begin with the first phone call, when the

parent calling for services gives an impression of how supportive or unsupportive they are of the youth's TGE identity or expressions. When parental attunement is low, we meet with parents separately from the child in order to give space for the parents' concerns without harmful messages sent to the child. In many cases when parental attunement is low, much of the therapy is with the parents, helping them to become more understanding and supportive of the youth. The goal is to eventually have family sessions, where the parents and the child can have healthy and productive discussions about gender expression and identity when it is an emotionally safe place for all members. The expectation is not that the communication will be without challenges, but ideally parents are not communicating to the child, "you are bad," or "something is wrong with you." Some families begin therapy with a high level of attunement, where parents are not expressing hurtful views about gender expansiveness. With these families, there is typically enough emotional safety already established and family sessions can take place at the onset of therapy.

Supporting Gender Expansiveness

Gender expansive youth often come to therapy having experienced a broad range of disapproval of and opposition to how they experience and express gender. The negative messages these youth receive from parents, siblings, peers, neighbors, teachers, media, etc. can be very damaging to the youth's sense of self-esteem. Therefore, part of the role of the therapist is to balance these negative messages by delivering positive messages about gender expansiveness and presenting an ideology that is grounded in "respect for the diversity of human gender expression" (Lev, 2004, p. 185). Therapists can create a "gender expansive safe zone," where youth are free to dress and express themselves in congruent ways and be called by their correct pronouns and chosen name. When youth declare their name/pronouns, it is important to ask youth what name/pronouns they would like the therapist to use when talking to parents.

It sometimes takes parents considerable time to adjust to new names and pronouns and therapists can gently explain the importance of these practices for the well-being of their child. Therapists can assist youth in expressing how hurtful it is each time their parent uses their assigned name and pronouns, because youth often feel as though it denies who they are as a person. While it is sometimes uncomfortable, therapists can begin to coach parents to use language that respects their child's gender identity, such as correcting them when they use assigned name and pronouns. Clearly, this directive technique should be balanced with a strong therapeutic alliance which is built with the parents. While supporting gender expansiveness is an important goal, supporting the family as a whole is equally important. Thus, parents are challenged by the therapeutic task of looking at their child's gender expansiveness in a new way, while at the same time feeling supported by the therapist in their own process. Additionally, therapists can assure youth that it is normal for parents to go through a time of adjustment, that parents typically become more accepting over time, and encourage them not to give up on their parents. When parents are having a particularly hard time adjusting to name/pronouns, the therapist can use *they/them* pronouns and gender-neutral language (i.e., "your child") in order to respect both the parents and the youth in their process.

Sometimes therapists also have a difficult time listening to and adjusting to a youth's chosen name and affirmative pronouns. In some cases, therapists are willing to attempt pronoun and name changes, but feel clumsy about it, especially when a youth's gender presentation does not fit neatly into binary ideas of gender. We encourage these therapists to stay curious about the youth's experience of their own gender and express to youth that they are learning, trying, and working on not making mistakes. It can be difficult to break habits learned by a culture that is so committed to binary and cisgender experiences, but in order for therapists to keep the TGE youth's best interest at heart, therapists must continue to challenge themselves to deconstruct these learnings

and change their behaviors to support and affirm youth. In other cases, therapists may minimize the importance of using correct name and pronouns or even be resistant to this affirmation, especially when parents are struggling to affirm youth in this way. We strongly encourage these therapists to examine their own assumptions about gender and their ideas about the "correct" ways to perform gender. It is also important that these therapists engage in continued education about TGE youth, learning about the harmful impacts on these youth when they are not affirmed, for example the high rates of suicidality (Grant et al., 2011; James et al., 2016; Travers et al., 2012). One study found specifically that using a TGE youth's correct name in more contexts was associated with lower depression, suicidal ideation, and suicidal behavior (Russell et al., 2018).

Psychoeducation with Parents

Gender affirmative therapy with parents often involves providing accurate gender education (Coolhart & Shipman, 2017; Lev, 2004). Parents may not understand the differences between concepts such as sex, gender identity, gender expression, and sexual identity. They may also have false ideas about their child's potential for a happy and successful life living in a TGE identity. Therapists can clarify concepts and assure parents that while TGE people often face challenges due to a society that is not yet fully understanding of TGE people, many TGE people live happy productive lives, including successful careers and families of their own.

In addition to providing accurate gender education, therapists can educate parents about the importance of parental support. Research consistently indicates that TGE people with highly rejecting parents may be at increased risk for suicide ideation and attempts, depression, illegal drug use, alcohol abuse, smoking, homelessness, engaging in unprotected sex, and sex work; those with supportive parents may experience higher self-esteem, social support, general health status, school belonging, academic achievement, life satisfaction, and overall mental health (Grant et al., 2011; James et al., 2016; Travers et al., 2012). As parents become aware that their level of support may have serious impacts on their child's mental and physical health, therapists can help coach them to decrease negative messages and increase supportive messages about their TGE identity and/or expressions. Sometimes it is not possible to change parents' beliefs immediately, but they can become aware of their behaviors that are harmful to their child and discontinue these behaviors while they work on their level of acceptance.

Parents also sometimes worry about what they may have done to cause their child to be TGE. Psychoeducation comes into play here as well, where therapists can help parents understand that being TGE is a natural variation of humanity and that TGE people have existed over time and across cultures. What is different now is that more children and adolescents have access to language that describes their experience of self and they have more accessible choices about how to live congruently.

Supporting the Parents' Emotional Process

Although parental reactions to TGE children differ widely, many parents experience a variety of challenging emotions, such as anxiety, embarrassment, worry, anger, concern, denial, grief, shame, self-blame, disappointment, loss, confusion, or fear for their child's safety (Brill & Pepper, 2008; Lev, 2004). Feelings of loss are particularly common for parents of TGE children (Coolhart et al., 2018), even when there is a high level of parental attunement. Parents may be mourning the child they thought they had and making space for the child they now have. Therapists can normalize these reactions and make space for them to be expressed. Parents sometimes express views that are in complete opposition to the views of the therapist. This can be challenging as a trans-affirmative therapist, but it is important to remember that many TGE kids, especially those with unsupportive parents, are in a high level of distress. Therefore, it is imperative that the therapist forms a strong relationship with parents in order to be able to

help alleviate the youth's distress. Therapy with these families can be seen as an isomorphic process, where the therapist creates a safe, accepting, supportive, and loving space for parents, and parents are then more able to provide this space for their child (Coolhart & Shipman, 2017). Underneath parents' negative attitudes are often love and concern, which can act as building blocks for the rest of the therapeutic work.

After parents have had space to express their thoughts and emotions, therapists can begin to explore the origins of these feelings. During this process, it is often helpful to understand how parents came to understand the concept of gender, for example, from messages received by their families of origin, religion, racial/ethnic community, or media. Therapists can begin to challenge parents to expand their views about gender by gently introducing new information into the system and addressing fears that may arise around a shifting view of gender. For example, a therapist might ask, "What if gender is more complex?" "How did you know what your gender was?" or "What if your child is having a similar experience of 'just knowing'?" Finally, parents often come to therapy wanting to know whether or not their child is "actually" transgender. They may wonder if early trans expressions will lead to a need to socially and/or medically transition. We encourage parents to focus on the journey and not the outcome (Coolhart & Shipman, 2017), emphasizing that what their child is experiencing right now is important and real for them. Therapists can encourage parents to respond to their child in the moment with compassion, patience, and support, ultimately learning to listen to what their child is telling them about their experiences of gender.

Engaging Siblings and Other Family Members in Therapy

Although some siblings express less distress about the TGE identity or expressions than parents, some express significant distress (Coolhart, 2018), and sometimes more than parents (Brill & Pepper, 2008). Siblings may experience loss, feeling like they are losing a brother for example, they may have concerns about peer reactions, or they may feel that all of the family's attention is being focused on the TGE child; and in some cases, siblings can become bullies to the TGE youth (Coolhart, 2018; Coolhart & Shipman, 2017). Therapists can make room for siblings' experiences in the context of family sessions and/or individual sessions and help siblings to process their emotions and gain strategies for dealing with challenges, such as when peers respond negatively.

However, siblings can sometimes be very helpful in families when they are supportive of the TGE youth. Growing up in a different time than their parents, siblings may have more inclusive and accepting attitudes about gender identity and expression and may actually help parents to also become more understanding. Siblings may be able to help normalize TGE experiences for parents and share their views of their sibling as just expressing who they are, which is positive, or maybe even that it is a non-issue. Support in families can sometimes be contagious when a struggling family member watches how another family member responds and adjusts to the TGE youth's emerging identity and/or expressions.

Other integral family members may also be involved in the therapeutic process in some families. Grandparents, for example, may need to work through emotions similar to those of parents and siblings. Essentially, it may make sense to include any family member that is experiencing or creating distress in the family system around gender (Coolhart & Shipman, 2017). As discussed above with regard to siblings, it can also be helpful to include other family members who are supportive of the TGE youth to help grow support in the family system.

Listening to Youth about What They Need to Feel Congruent

TGE youth have diverse experiences of self. While some youth very clearly and persistently assert a gender identity that is different from their assigned sex, other youth are communicating a need for expressions that are considered "cross-gender." This latter group of children have been

referred to as "gender expansive" and these youth may feel that their assigned sex fits just fine as long as their gender expressions are not policed (Ehrensaft, 2018). Gender expansive youth may not ever need to transition to another gender identity; rather, they may just need to feel free in their expressions to feel congruent. For example, a four-year-old assigned male at birth may not be expressing a transgender identity ("I am a girl"), but may be desiring to grow long hair or wear skirts; or a 16-year-old assigned female may identify as female and still feel dysphoria about chest, desiring to bind chest and/or undergo breast reduction or chest reconstruction surgery. In order to promote gender health, therapists can help parents support their child's gender creativity and help manage situations in which these behaviors are policed (Ehrensaft, 2018), such as school and other public spaces or with extended family and friends.

Another experience that is common for youth is to express identities often called non-binary, agender, genderqueer, or gender fluid. These youth may identify as both female and male, neither female nor male, or more female at times and more male at other times. Similar to the treatment approach for gender expansive youth, therapists can help families support whatever gender expressions feel congruent for the youth. Non-binary experiences of gender may or may not include body dysphoria. Body dysphoria experienced by non-binary youth may be less intense than binary trans youth (Ehrensaft, 2018), though some non-binary youth may desire social transition and/or medical treatments, such as hormone therapy or chest reconstruction surgery. They may also request the use of gender-neutral pronouns, such as they and them. For example, a 14-year-old assigned male may see themself as not really fitting into male or female categories, prefer they/them pronouns, and assert a variety of outward expressions which include what have been traditionally considered feminine expressions, such as wearing makeup, nail polish, and colorful clothing.

Other TGE youth present in therapy with a binary gender identity (female or male) that is different from their assigned sex. These youth may assert their identities very early, such as a four-year-old assigned female who insists that he is a boy and throws tantrums every time he is forced to wear dresses. Other times these youth assert their identities later, such as a 13-year-old assigned male who has always felt uncomfortable in a masculine role and, after learning about transgender experiences, now understands that she is in fact female and desires feminizing hormones. In the field of trans healthcare, it has historically been controversial whether or not youth should be "allowed" to transition, especially prepubescent children. However, a growing body of research is supporting early transition for youth who assert a clear gender identity, informing the increased application of gender affirmative care, including transition, for youth. Several studies suggest that youths who are clear at an early age and allowed to socially transition are functioning psychologically as well as cisgender peers (Durwood et al., 2017; Olson et al., 2015, 2016). Older adolescents and adults who were not allowed to transition in childhood experience increased depression, anxiety, and suicide attempts (Budge et al., 2013; Reisner et al., 2015). Additionally, the younger a person is when they are allowed to transition, the better their mental and physical health outcomes (Robertson, 2016).

There may be reasons for delaying decisions regarding gender transition for some youth such as youth's confusion or ambivalence about gender transition, lack of support, or lack of psychological resilience (de Vries et al., 2006). However, in many cases, it is appropriate to support youth and families in exploring gender transition options. Coolhart and Shipman (2017) provide a model for making decisions with families about transition, focusing on the variables of distress and persistence. Particularly when youth are experiencing high levels of distress and demonstrate both diligence and consistency with their gender identity, moving forward in transition may be urgent for the youth's mental health. Coolhart et al. (2013) present a clinical tool to assist therapists in making determinations about the readiness of youth and their families for medical gender transition. This tool can serve as a guide through a process that is complex and, for most therapists, unfamiliar.

Transition is a process that involves many steps; youth can be supported in taking small steps in the process and therapists can then check in to make sure the steps taken are resulting in increased feelings of congruence. This is particularly true of social transition, which does not involve medical intervention, and typically includes coming out to others and choosing clothing, hairstyle, name, and pronouns that feel congruent with the youth's gender identity. For example, a youth may be supported in using their chosen name and pronouns, perhaps only at home at first, and then after checking in to make sure this resulted in increased congruence, other steps in transition may be taken.

As puberty draws near, some youth desire the use of hormone blockers to delay puberty. Pubertal delay is not necessarily a first step that inevitably leads to gender transition; rather, it can also be a diagnostic tool, allowing the youth, family, and therapist to explore gender with less of a time constraint (de Vries et al., 2006; Giordano, 2008). During pubertal delay, youth have time to "try on" their gender before initiating less reversible treatments and parents have time to process their child's gender transition (Coolhart et al., 2013). Because TGE youth undergoing the puberty of their assigned sex often experience anxiety, anguish, depression, and confusion (Coolhart et al., 2013; Lev, 2004), pubertal delay may also reduce the youth's psychological distress. A further advantage to pubertal delay is that it keeps the bodies of youth from experiencing the puberty of their assigned sex and developing in the "wrong" direction; therefore, youth have more body satisfaction and are more easily able to blend in with cisgender peers without being identifiable as trans (Giordano, 2008). Youth who delay puberty also may desire fewer treatments and surgical procedures later in the transition process because their bodies have not developed secondary sex characteristics of the assigned sex (Coolhart et al., 2013). Finally, pubertal delay is fully reversible and can be discontinued at any time and the puberty of the assigned sex will begin.

As youth progress in gender transition, many of them wish to initiate affirmative hormonal therapy. Youth beginning feminizing or masculinizing hormonal treatment experience pubertal changes that are typical of their gender identity. Youth initiating female puberty may experience breast growth, feminine muscle and fat distribution, and softening of skin; youth initiating male puberty may experience voice deepening, face and chest hair growth, masculine muscle development, and clitoral enlargement. Many youth beginning hormone therapy experience excitement and relief because their physical bodies are becoming more congruent with their internal sense of self (Coolhart et al., 2013). When initiating hormonal treatment, families should be aware that this choice is not fully reversible. Most of the youth's bodily changes will reverse if the hormonal treatment is discontinued, such as muscle and fat distribution and changes in emotionality and skin. However, there are some changes that are not reversible, such as breast growth, voice pitch drop, and facial/chest hair.

Long-term data on the health risks of hormonal intervention in youth are not available due to the relative newness of the gender affirmative approach. Although there are some potential risks involved in these treatments, such as the loss of reproductive ability, the benefits to the child's mental health and future adult functioning often heavily outweigh the risk (Sills, 2019). Therapists should become educated on both the impacts and risks of hormone therapy so all of these considerations can be discussed. Therapists can also help parents to understand the mental health benefit for their child and help them accept the unknown (Sills, 2019).

Finally, at the time of this writing, and to the best of our knowledge, genital surgery is not available for youth under the age of 18. However, this could change in the future as trans healthcare continues to become more affirmative. Currently, some transmasculine youth are undergoing chest reconstruction surgery, which can often eliminate chest dysphoria, which is often very distressing.

Therapists as Advocates

Therapists working with TGE youth may often find that their role extends outside of the therapy room as an educator and advocate, particularly in the school setting (Coolhart, 2019). Therapists can assist their clients in being treated with more care and consideration by being willing to speak with adults (teachers, administrators, mentors, pastors, etc.) involved in the lives of TGE youth. In the school setting, therapists may advocate for trans-friendly actions, such as using chosen name and pronouns; updating policies and forms; providing training and education for students, staff, and parents; adopting a zero-tolerance policy for discrimination; and allowing the youth to use bathrooms, locker rooms, dress codes, and participate in gym class activities that are congruent with the student's gender identity (Brill & Pepper, 2008; Coolhart, 2019). Therapists can further this advocacy by talking with the youth and family to assess where more education is needed. Then, therapists can take actions such as writing letters of support, arranging meetings with key teachers and administrators, or making phone calls to school psychologists, the principal, or the youth's teacher. Some youth and/or parents are able to advocate for themselves and therapists can discuss strategies for this self-advocacy.

Connecting Family to Support Systems

TGE youth and families may feel isolated in their experience and it can feel very validating for youth, parents, and families as a whole to feel connected to others that share similar experiences. Therapists should become aware of local resources available for TGE youth and their families (Coolhart et al., 2013), such as support groups for TGE youth and support groups for parents of TGE youth. Therapists can also encourage families to reach out for support online, connecting to organizations that organize events for families of transgender youth, such as weekend retreats or youth summer camps (Coolhart, 2012).

Intersectional Considerations for TGE Youth

The therapeutic relationship and outcomes of therapy can achieve greater success if the therapist utilizes an intersectional approach, addressing aspects of oppression not only related to gender identity, but also related to other marginalized identities, such as race/ethnicity, socioeconomic class, and religion. Intersectionality affirms that an individual holds multiple identities, which interact and shape experiences (Golden & Oransky, 2019). Identities cannot remain isolated as this creates identity erasure (over-focusing on one aspect of identity while ignoring another), and instead by remaining intersectional, the sums of all parts are included. Those in privileged spaces that hold power create additional discrimination for marginalized groups (Cho et al., 2013). Thus, gender identity can often be better understood in the context of the family's multiple identities (Golden & Oransky, 2019), and therapists can address the multilayers of oppression and experiences that TGE youth and their families may encounter. Here we address some of the intersectional challenges youth and families may face, specifically with regard to race/ethnicity, socioeconomic status, and religion.

Race/Ethnicity

The historical and ongoing fight for racial equality and justice creates a multilayered challenge for youth who identity as both TGE and a youth of color (Singh, 2013). Those that occupy both spaces often experience an intersection of racism and transphobia from interpersonal and environmental contexts leading to greater minority stress. Reisner et al. (2015) highlighted the increased substance use, suicidal ideation, and negative mental health outcomes in participants who identified as both a racial/ethnic minority and within the LGBTQ community. A trans youth who is also a person of color may feel accepted in one space, but disregarded in another. Those with multiple intersectional identities may have to decide which part of self to identify

with that day, depending on the space they are occupying. For example, a trans youth that identifies as TGE and Black may have difficulty finding a TGE support group that includes other Black youth. However, the youth may experience transphobia in the Black community, lack of representation in their social group, low family support, and lack of access to trans support groups (Singh, 2013). Brown and Mar (2018) discussed a similar concept, *cultural splitting*, in which a dominant group sets apart a marginalized group and imposes their own values upon them. For TGE youth, this may manifest in clinicians imposing a monolithic view of coming out based on dominant white narratives, taking on the role of being a "white savior," and internalizing assumptions about communities of color being less supportive of TGE identities, which is often not the case (Brown & Mar, 2018).

Trans youth of color are twice as likely to experience discrimination and often experience limited access to resources (Lefevor et al., 2019). A racial minority family that is seeking mental or medical health assistance for their TGE child may encounter an inability to access adequate services (Lefevor et al., 2019). As these families encounter minority stress from systemic oppression, they can face mental health disparities from the multiple intersections of gender identity and race. There is often low racial representation in the media of trans people of color and often only negative statistics related to violence are reported. Additionally, low racial representation is apparent in products used to relieve dysphoria for trans youth such as binders (products that aid compressing the chest to appear more masculine) and packers (products that aid in giving the appearance of a penis), as noted from a participant of color in Martin and Coolhart's (2019) qualitative study. Often these products are not inclusive and are produced only using white skin tone, leaving a person of color unable to match the product with their skin color.

As the current political climate threatens the safety of TGE people at large, it is extremely vital that families consider the benefits of allyship for their family member, moving toward affirmation and social justice. Social support, specifically from families, has been widely cited as a factor in increasing resilience and mental health, resisting the effects of oppression (Chan, 2018; Golden & Oransky, 2019). As a result, when working with TGE youth of color and their families, we suggest therapists:

- Remain curious about the unique ways in which the family understands TGE identities through the lens of their racial/ethnic identity. Therapists can ask families of color what messages they have received from their culture about TGE people and discuss how these messages are impacting their feelings about their TGE youth. For example, a Chinese-American family may be organized by cultural messages of traditional gender roles, and, coming from a collectivist cultural perspective, may feel that their child who was assigned male brings shame to the family when they express femininity.
- Seek to understand how racism impacts the family and the challenges they may be facing while supporting the TGE youth within their racial community. For example, a therapist may ask a Black family about their experiences of racism in mainstream U.S. culture, validating when the family feels devalued and mistreated. The family may report that having these experiences in the larger culture makes it all the more important to connect within their Black community. This can create a struggle because they may feel their transgender child is rejected within their racial community, making it difficult to balance community connectedness and supporting their child.
- Help families see the connection between multiple forms of oppression (i.e., using the family's experiences with racism to help them understand their child's experiences with transphobia). For example, a Mexican-American family might report feeling like they do not have access to reliable and well-paying employment because of their ethnic background, trapping them in a cycle of poverty. Therapists can validate this unfairness

in the larger social structure that leads to Mexican-American people living in poverty at a disproportionate rate. The feelings this family has around being devalued can be compared to how TGE people are also mistreated, who are also living in poverty at a disproportionate rate. This connection may allow the family to have increased compassion for their TGE child, understanding that they are now facing a similar and familiar structure of oppression.

- Attend to cultural representation (such as having staff of color and including racial/ethnic images in office spaces as well as providing language accessibility for families who speak a language besides English (Brown & Mar, 2018)).
- Help families explore options about how to thoughtfully engage in *identity management* (Connolly, 2012), where the support or expression of the TGE youth may look different depending on context (at home, school, within their racial community, etc.). For example, an Indian-American family may choose to support their child's gender expression at home, but not feel safe to allow their child's authentic gender expression in public spaces where their connection to their cultural community could be damaged.

Socioeconomic Status

The systemic barriers to care for trans people often begin at the federal level and trickle down. For example, the administration at the time of this writing is striving to remove transgender care from the Affordable Care Act, along with multiple state-level protections, leaving trans people to face increased stressors (White Hughto et al., 2017). When seeking medical and mental health care, TGE people often encounter discrimination, poor treatment, abuse, lack of appropriate care, and a lack of competence (Romanelli & Hudson, 2017). Further, those with intersectional marginalized identities such as race or low socioeconomic class may encounter further restrictions to care. Those in low-income areas may experience issues surrounding availability of services for their family, transportation issues, and a lack of community services overall (Romanelli & Hudson, 2017). TGE youth and their families may face structural barriers that lead to poor health such as provider discrimination, restrictive insurance policies, and limited educational opportunities (White Hughto et al., 2017).

Barriers to medical transition services include the affordability of insurance and geographical restrictions. Even for those who have access to insurance for therapy services, puberty blockers, hormone therapy, and gender confirmation surgery coverage, there are often additional out of pocket costs such as postoperative care, deductibles, supplies, and complications. For those families that do not have the resources or financial means, medical transition may not be accessible for these TGE youth. Youth may feel additional stress because of these costs and the burden they place on their already financially strained family (Brown & Mar, 2018). Often in order to get their needs met, TGE people may access alternative forms of care through the black market, often resulting in dangerous side effects (Romanelli & Hudson, 2017).

As therapists working within a socioeconomically oppressive system, it is important to do what we can to increase accessibility and affordability to low-income families. Therapists can:

- Advertise a sliding scale for clients.
- Engage in community involvement and offer services in urban and low-income areas.
- Advocate for larger systemic changes by getting involved in panels and practices that affirm trans identities.
- Demonstrate trans-inclusion in office spaces. For example, in clinics serving low-income clients, intake forms can include options for TGE identities and leave space to ask about chosen name and pronouns. Also, posters with trans-affirmative messages and/or flyers for local trans-related medical care can be displayed.

Religion

While more and more religious institutions are adopting LGBTQ-affirmative stances, there are still many religious traditions that overtly disapprove of LGBTQ identities and discourage, deny, and shame LGBTQ people. When TGE youth and their families are embedded in these traditions, youth may grow up with increased gender shaming and thus harbor high levels internalized transphobia. Beagan and Hattie's (2015) study of LGBTQ adults found that faith traditions often negatively affected participants, including experiences of shame, guilt, sex negativity, disconnecting from body, and severing of relationships to self and others. While many traditional religious messages focus on anti-LGB sentiments, traditional religions also target TGE folks in a different way. In many religions, messages about gender expectations and religion are deeply connected, based on cisgender realities, and ignore the existence of TGE experiences (Sumerau et al., 2018).

TGE youth may not only be struggling with high levels of internalized transphobia, but they may also be dealing with a higher risk for family and/or community rejection. Research indicates that LGBTQ youth are at greater risk of homelessness (2–13 times) than their heterosexual cisgender counterparts, and that they are more likely to leave home as the result of physical abuse at home, often because of conflicts with parents about sexual identity (Cochran et al., 2002; Corliss et al., 2011). TGE youth from traditional religious families may need to engage in identity management, potentially not coming out to parents or expressing their gender expression only outside of the home (i.e., school, youth groups) in order to maintain their safety and housing.

TGE youth and their parents may also be struggling with their own personal relationship to their faith, trying to balance a belief system that does not support TGE identities with the reality of having a TGE child. Therapists can help both youth and parents explore and expand their belief systems, focusing more on faith, and become more supportive of the TGE identity. In some cases, beliefs are not flexible and therapists can help families negotiate a way for them to maintain their beliefs while also maintaining a relationship with their TGE child. We suggest therapists working with these families:

- Talk directly about the family's religious beliefs, understanding both the core tenets of the religion and the specific beliefs that do not support TGE identities.
- Explore the role religion plays in the family's life, including how other intersections may be involved, such as a connection to a racial/ethnic community.
- Use strengths in religious beliefs to facilitate loving relationships, despite differences in beliefs (i.e., unconditional love of children, importance of family).
- Expand and challenge parents' religious beliefs, when possible.
- Encourage families to explore affirming religious institutions and/or engage in conversations with affirming religious leaders.
- Separate institutionalized religion from individuals' personal relationship with their faith (Beagan & Hattie, 2015), where the person may hear anti-LGBTQ messages in the context of the religious institution but may experience peace about LGBTQ identities when in prayer, meditation, or other times when they are feeling personally connected to their God or other faith figure.
- Coach parents to limit their expression of these beliefs to their child when harmful beliefs are immovable. For example, if parents have already told their child multiple times that they will go to hell because of their identity, therapists can ensure that this message has been heard by the child and does not need to be repeated. The goal here is to reduce the amount of negative expressions, even if the beliefs stay the same.

Relational Intersectionality and Self-of-the-Therapist

Building on others' concepts of intersectionality, Addison and Coolhart (2015) proposed a *relational intersectional lens*, which recognizes the importance not only of clients' unique intersecting identities, but also emphasizes the interplay of therapists' intersections. In our work with clients, our identities show up in the room and interact with clients' identities. We suggest therapists engage in self-of-the-therapist work around this dynamic, staying aware of how our intersections impact our work with families. To provide some context for this concept, both authors will describe some of the ways in which we have engaged in this process and how we stay aware of our relational intersectionality.

First Author's (DC) Relational Intersectionality

I identify as a white cisgender pansexual female who has a high level of education and middle SES. I am also a single mother of a teenage cisgender son. I have specialized in working with TGE people and their families for 20 years. When I began working with this population, I would almost always disclose my queer identity in order to join with clients as part of their larger community. I often found that clients had negative experiences with professionals who were supposed to be helpful; thus, they were initially mistrustful of me. This has shifted over the years, probably because of my reputation as a gender affirmative therapist; therefore, I now only occasionally disclose my sexual identity, and only when it seems relevant to families' challenges. I find that disclosing my identity as a mother is very helpful in my work with TGE youth and their families, allowing me to "straddle" my role in supporting TGE youth and also demonstrating compassion for parents as they are struggling to adjust to their child's identity.

In my work with families, I must also attend to my privileged identities with regard to race, education, and SES. When I am working with families of color, I often begin conversations about race, validating experiences of devaluation and discrimination, attempting to make these conversations safe and not "off limits" for clients. The privilege that comes with my level of education can often be used to help advocate for youth and families in contexts outside of the therapy room, where school staff, for example, will respond to an "expert" in ways they don't to the voices of youth and families. As a private practice clinician, my services are often not accessible to low SES clients. As a way to counter this challenge, I created a Gender Expansive Support Team, comprised of student therapists working in my University's free mental health clinic.

Second Author's (TKM) Relational Intersectionality

I identity as a straight man who is white, Christian, and highly educated, and a middle-class SES. My gender history includes being assigned female at birth, but always identifying as male and taking medical steps to become congruent. As a therapist with personal experience and connection to my trans clients, I sometimes encounter situations in which disclosing my gender history is clinically necessary and benefits the therapeutic relationship. In these situations, it has resulted in therapeutic strength and positive outcomes for the family. My reasoning behind limited disclosure is mainly safety and feeling that the complexity and intimacy of my gender is personal. When working with children, I am cautious to discuss my experiences because parents might feel that I am biased. My gender identity aids in understanding body dysphoria, creating a connection and assisting in navigating this in multiple systems.

Often, I am reflective of my other identities that affect the therapeutic relationship. For example, my experience as a white, educated man holds privilege in society that I address in order to validate those with other racial, educational, or gender experiences. As a Christian, I have used my identity to create solace with clients who were struggling to accept their identity of being both spiritual and TGE. Additionally, my personal experience and educational background

allows me to share first-hand factual knowledge that is often misconstrued online or in the media. During these moments, I validate both the child and parents, leaving space for conversation that allows me to connect to their experiences. Therapist self-disclosure allows families to express their own identities with fears and concerns for their child's future; by sharing my experiences together, we can build a model of resiliency and hope.

Case Example

Both authors had the opportunity to work with this family at two different points in time. The first author worked with them when they presented with a seven-year-old assigned male who enjoyed expressing femininity. The second author began working with the family seven years later when the now 14-year-old youth was describing their gender as a girl. Thus, this vignette reflects these two different times in this family's life. While identifying details have been changed, this family gave permission for us to share our story of therapy with them. We will use "they/them" pronouns for Jordan, the TGE youth, since their gender identity has shifted over time and they have not yet begun using feminine pronouns.

When the family began therapy with me (DC), they presented as a white gay male couple adopting two children, both assigned male at birth and biologically related to each other as half-siblings. The younger child, Jordan, was seven at the time and racially identified as Black and white. The older child, Marcus, was eight and multiracial of unknown race. From the initial phone call, it was clear that parental attunement was high, as the parents described Jordan as a kid who liked to dress up in princess dresses and other clothing considered feminine. They expressed that they were comfortable with whatever Jordan needed and were seeking assistance in figuring out just what they needed. Therefore, we initiated therapy with family sessions involving all four members, and eventually also had individual sessions with both kids and couple sessions to support parenting.

As I explored gender identity with Jordan, they didn't seem solidly female or male; rather, they seemed ambivalent and not really concerned about identifying as a gender. They seemed comfortable with both social roles, not bothered by being grouped with the boys for example, though they were upset if they were not allowed to express femininity at times. As I asked Jordan questions about their comfort level with their body, there did not seem to be any body dysphoria. Because Jordan was not asserting a female gender identity and was not reporting significant distress or dysphoria, I was conceptualizing them as a gender expansive child. I supported their gender expansiveness in sessions and created opportunities for feminine expression through art and by having dresses, scarves, and purses available for dress up during sessions.

Supporting Jordan's gender expansiveness was also my goal with the family. While the whole family was supportive of Jordan's expressions at home, there were concerns about Jordan expressing femininity at school. Marcus was anxious about peer reactions and we discussed how he might handle different situations. We talked about what the other kids might say and how he could respond. While we talked about strategies that could deflect other kids' comments, Marcus seemed most comfortable with a protective stance, where he stood up for his sibling, responding with something like, "Look, this is just how my brother is…get over it!" Sessions with the parents also focused on supporting Jordan's expressions in larger systems, particularly how they could advocate for Jordan at school. They had conversations with Jordan's teacher and school administrator to make sure they would protect Jordan when they wore feminine clothing to school.

I also coached the parents on having age appropriate conversations with the kids about systems of oppression. This was particularly important because Jordan definitely wanted to dress as they wished but didn't necessarily understand the potential social consequences. We practiced

conversations about making decisions to dress in different spaces, the structural oppression that leads sometimes to negative reactions from others, and strategies for dealing with mistreatment. Since the family was interracial and gay-parented, I encouraged the parents to keep conversations about race open, especially as white parents, and made connections between the couple's experiences with homophobia to experiences the kids may have with racism. Therapy with me (DC) ended about a year later when the family was able to fully support Jordan's gender expansiveness. I encouraged them to continue to listen to Jordan's potentially changing needs and to wait and see about whether or not transition would become important to them.

The family began therapy with me (TKM) 7 years later, when the kids were 14 and 15. The initial contact involved concern for Marcus, who was expressing suicidal ideations at school. After a few sessions of meeting with this client, one dad expressed that Jordan also expressed a desire to meet with a therapist. Dad disclosed that Jordan had met with the previous therapist (DC) years ago and explored gender history, but now was being more direct in their desire to be a girl.

My initial sessions included joining with Jordan and discussing their love for fashion and jewelry. From my sessions with older brother Marcus, I gathered that both teens have a history of trauma that resulted in different types of emotional expression. Marcus on one hand often expressed anger but was very willing to disclose his experiences, whereas Jordan resisted disclosing their experiences, and it took a few sessions to create a safe space.

About five sessions in Jordan disclosed to me that they think they are transgender; they stated that they have the desire to live life as a girl and referenced not wanting to experience the changes that their older brother was going through. Since my client's developmental stage presented urgency for puberty blockers if desired, we dove right into exploring their gender. Jordan enjoyed discussing their feminine attributes and feelings of being a girl, they expressed that they do not want to change their name or pronouns right now, but expressed not wanting to go through male puberty. We discussed their desire for medical transition in the future and decided to bring dads in for the next session.

During this family session, dads expressed support for Jordan and wanting them to be their true self. They expressed their fears around their child's safety, specifically if they decided to transition. Together we discussed the horrific experiences of many trans women of color in society. I validated this moment and described my experience of living in the south and not feeling safe within LGBTQ spaces. I joined in understanding their fears and also ways in which I navigated safety as a marginalized individual. During this time, Jordan expressed their struggles of not having any Black female role models and was uncertain about how to navigate femininity. We offered support by describing TV shows and social media that provide representation of Black trans feminine people. We decided that Jordan would determine when they wanted to medically transition, but in the coming months, they would make a social transition to their chosen name and pronouns.

At this point in time, therapy is ongoing, and the family is maintaining a "wait and see" approach. My sessions with Marcus often explore his trauma and experiences of being a straight male in a gay and gender expansive family. Sessions with Jordan often include discussion around their trauma and experience of gender and race in a majority white/male household. With both of the teens, I model acceptance and support of their journeys, often reflecting on my relationships with others throughout the years while finding my own identity. Jordan has found that they often lean on their friends to provide tips for fashion and makeup. They express that they envision themselves as a woman in the future but they are happy with their gender presentation now, being able to express femininity and support from their parents who are actively ready to give the green light toward medical transition when/if Jordan expresses the need.

Conclusion

Therapy with TGE youth and families can be challenging work, especially when parents struggle to support their TGE child. However, it can be wonderfully rewarding work to help TGE youth find congruence between expression, body, and mind, often leading to being much happier human beings. Our job as therapists working with these families is to remain intersectional in our thinking, compassionately hold parents in their emotional experiences, and gently nudge them toward increased support of their child. Most of all, we need to really tune in and listen to what youth are telling us they need and thoughtfully follow their lead to promote their gender health.

References

Addison, S., & Coolhart, D. (2015). Expanding the therapy paradigm with queer couples: A relational intersectional lens. *Family Process, 54*(3), 435–453. https://doi.org/10.1111/famp.12171

Beagan, B. L., & Hattie, B. (2015). Religion, spirituality, and LGBTQ identity integration. *Journal of LGBT Issues in Counseling, 9*(2), 92–117. https://doi.org/10.1080/15538605.2015.1029204

Brill, S., & Pepper, R. (2008). *The transgender child: A handbook for families and professionals*. Cleis Press Inc.

Brown, E., & Mar, K. (2018). Culturally responsive practice with children of color. In C. Keo-Meier & D. Ehrensaft (Eds.), *The Gender Affirmative Model: An interdisciplinary approach to supporting transgender and gender expansive children* (pp. 55–69). American Psychological Association.

Budge, S. L., Adelson, J. L., & Howard, K. A. (2013). Anxiety and depression in transgender individuals: The roles of transition status, loss, social support, and coping. *Journal of Consulting and Clinical Psychology, 81*(3), 545–557. https://doi.org/10.1037/a0031774

Chan, C. D. (2018). Families as transformative allies to trans youth of color: Positioning intersectionality as analysis to demarginalize political systems of oppression. *Journal of GLBT Family Studies, 14*(1–2), 43–60. https://doi.org/10.1080/1550428X.2017.1421336

Cho, S., Crenshaw, K. W., & McCall, L. (2013). Toward a field of intersectionality studies: Theory, applications, and praxis. *Signs: Journal of Women in Culture and Society, 38*(4), 785–810. https://doi.org/10.1086/669608

Cochran, B. N., Stewart, A. J., Ginzler, J. A., & Cauce, A. M. (2002). Challenges faced by homeless sexual minorities: Comparison of gay, lesbian, bisexual, and transgender homeless adolescents with their heterosexual counterparts. *American Journal of Public Health, 92*(5), 773–777. https://doi.org/10.2105/AJPH.92.5.773

Connolly, C. M. (2012). Lesbian couple therapy. In J. J. Bigner & J. L. Wetchler (Eds.), *Handbook of LGBT-affirmative couple and family therapy* (pp. 43–56). Routledge.

Coolhart, D. (2012). Supporting transgender youth and their families in therapy: Facing challenges and harnessing strengths. In J. J. Bigner & J. L. Wetchler (Eds.), *Handbook of LGBT-affirmative couple and family therapy* (pp. 199–214). Routledge.

Coolhart, D. (2018). Helping families move from distress to attunement. In C. Meier & D. Ehrensaft (Eds.), *The Gender Affirmative Model: An interdisciplinary approach to supporting transgender and gender expansive children* (pp. 125–140). American Psychological Association.

Coolhart, D. (2019). Please stop calling my daughter 'he': Advocating for teens and pre-teens in the school setting. In A. I. Lev & A. Gottlieb (Eds.), *Families in transition: Parent perspectives on raising the gender nonconforming or trans child.* Harrington Park Press.

Coolhart, D., Baker, A., Farmer, S., Malaney, M., & Shipman, D. (2013). Therapy with transsexual youth and their families: A clinical tool for assessing youth's readiness for gender transition. *Journal of Marital and Family Therapy, 39*(2), 223–243. https://doi.org/10.1111/j.1752-0606.2011.00283.x

Coolhart, D., & Mason, B. (2017). Gender dysphoria and systemic meaning. In J. Russo, K. Cocker, & J. King (Eds.), *DSM-5 and family systems* (pp. 351–375). Springer.

Coolhart, D., Provancher, N., Hager, A., & Wang, M. (2008). Recommending transsexual clients for gender transition: A therapeutic tool for assessing readiness. *Journal of GLBT Family Studies, 4*(3), 301–324. https://doi.org/10.1080/15504280802177466

Coolhart, D., Ritenour, K., & Grodzinski, A. (2018). Experiences of ambiguous loss for parents of transgender male youth: A phenomenological exploration. *Contemporary Family Therapy, 40*(1), 28–41. https://doi.org/10.1007/s10591-017-9426-x

Coolhart, D., & Shipman, D. L. (2017). Working towards family attunement: Family therapy with transgender and gender nonconforming children and adolescents. *Psychiatric Clinics of North America, 40*(1), 113–125. https://doi.org/10.1016/j.psc.2016.10.002

Corliss, H. L., Goodenow, C. S., Nichols, L., & Austin, S. B. (2011). High burden of homelessness among sexual-minority adolescents: Findings from a representative Massachusetts high school sample. *American Journal of Public Health, 101*(9), 1683–1689. https://doi.org/10.2105/AJPH.2011.300155

de Vries, A. L. C., Cohen-Kettenis, P. T., & Delemarre-van de Waal, H. (2006). Clinical management of gender dysphoria in adolescents. *International Journal of Transgenderism, 9*(3/4), 83–94. https://doi.org/10.1300/J485v09n03_04

Durwood, L., McLaughlin, K. A., & Olson, K. R. (2017). Mental health and self-worth in socially transitioned transgender youth. *Journal of the American Academy of Child & Adolescent Psychiatry, 56*(2), 116–123. https://doi.org/10.1016/j.jaac.2016.10.016

Ehrensaft, D. (2018). Exploring gender expansive expressions versus asserting a gender identity. In C. Meier & D. Ehrensaft (Eds.), *The Gender Affirmative Model: An interdisciplinary approach to supporting transgender and gender expansive children* (pp. 37–53). American Psychological Association.

Ehrensaft, D., Giammattei, S. V., Storck, K., Tishelman, A. C., & Keo-Meier, C. (2018). Prepubertal social gender transitions: What we know; what we can learn—A view from a gender affirmative lens. *International Journal of Transgenderism, 19*(2), 251–268. https://doi.org/10.1080/15532739.2017.1414649

Giordano, S. (2008). Lives in a chiaroscuro: Should we suspend the puberty of children with gender identity disorder? *Journal of Medical Ethics, 34*(8), 580–584. http://dx.doi.org/10.1136/jme.2007.021097

Golden, R. L., & Oransky, M. (2019). An intersectional approach to therapy with transgender adolescents and their families. *Archives of Sexual Behavior, 48*(7), 2011–2025. https://doi.org/10.1007/s10508-018-1354-9

Grant, J. M., Motett, L. A., Tanis, J., Harrison, J., Herman, J. L., & Keisling, M. (2011). *Injustice at every turn: A report of the national transgender discrimination survey.* National Center for Transgender Equality and National Gay and Lesbian Task Force.

Grossman, A. H., D'Augelli, A. R., Howell, T. J., & Hubbard, S. (2005). Parents' reactions to transgender youths' gender nonconforming expression and identity. *Journal of Gay & Lesbian Social Services, 18*(1), 3–16. https://doi.org/10.1300/J041v18n01_02

Hidalgo, M. A., Ehrensaft, D., Tishelman, A. C., Clark, L. F., Garofalo, R., Rosenthal, S. M., Spack, N. P., & Olson, J. (2013). The gender affirmative model: What we know and what we aim to learn. *Human Development, 56*(5), 285–290. https://doi.org/10.1159/000355235

James, S. E., Herman, J. L., Rankin, S., Keisling, M., Mottet, L., & Anafi, M., (2016). *The repost of the 2015 U.S. Transgender Survey.* National Center for Transgender Equality.

Keo-Meier, C., & Ehrensaft, D. (2018). Introduction to the gender affirmative model. In C. Keo-Meier & D. Ehrensaft (Eds.), *The Gender Affirmative Model: An interdisciplinary approach to supporting transgender and gender expansive children* (pp. 3–19). American Psychological Association.

Lefevor, G. T., Janis, R. A., Franklin, A., & Stone, W. M. (2019). Distress and therapeutic outcomes among transgender and gender nonconforming people of color. *The Counseling Psychologist, 47*(1), 34–58. https://doi.org/10.1177/0011000019827210

Lev, A. I. (2004). *Transgender emergence: Therapeutic guidelines for working with gender variant people and their families*. The Haworth Clinical Practice Press.

Martin, T. K., & Coolhart, D. (2019). *Because your dysphoria gets in the way of you…it affects everything: Trans masculine people navigating dysphoria and sex* [Manuscript submitted for publication].

Olson, K. R., Durwood, L., DeMeules, M., & McLaughlin, K. A. (2016). Mental health of transgender children who are supported in their identities. *Pediatrics, 137*(3), e 20153223. https://doi.org/10.1542/peds.2015-3223

Olson, K. R., Key, A. C., & Eaton, N. R. (2015). Gender cognition in transgender children. *Psychological Science, 26*(4), 467–474. https://doi.org/10.1177/0956797614568156

Reisner, S. L., Vetters, R., Leclerc, M., Zaslow, S., Wolfrum, S., Shumer, D., & Mimiaga, M. J. (2015). Mental health of transgender youth in care at an adolescent urban community health center: A matched retrospective cohort study. *Journal of Adolescent Health, 56*(3), 274–279. https://doi.org/10.1016/j.jadohealth.2014.10.264

Robertson, S. (2016). *Transgender people: Adversity and relationship to complex trauma* [Unpublished doctoral dissertation]. Alliant International University.

Romanelli, M., & Hudson, K. D. (2017). Individual and systemic barriers to health care: Perspectives of lesbian, gay, bisexual, and transgender adults. *American Journal of Orthopsychiatry, 87*(6), 714–728. https://doi.org/10.1037/ort0000306

Russell, S. T., Pollitt, A. M., Li, G., & Grossman, A. H. (2018). Chosen name use is linked to reduced depressive symptoms, suicidal ideation, and suicidal behavior among transgender youth. *Journal of Adolescent Health, 63*(4), 379–380. https://doi.org/10.1016/j.jadohealth.2018.02.003

Sills, I. N. (2019). But doc, is it safe?: Effects of pubertal suppression and trans hormone therapy for youth. In A. I. Lev & A. R. Gottlieb (Eds.), *Families in transition: Parenting gender diverse children, adolescents, and young adults* (pp. 232–249). Harrington Park Press.

Singh, A. A. (2013). Transgender youth of color and resilience: Negotiating oppression and finding support. *Sex Roles, 68*(11–12), 690–702. https://doi.org/10.1007/s11199-012-0149-z

Stone Fish, L., & Harvey, R. G. (2005). *Nurturing queer youth: Family therapy transformed.* Norton.

Sumerau, J. E., Mathers, L. A. B., & Cragun, R. T. (2018). Incorporating transgender experience toward a more inclusive gender lens in the sociology of religion. *Sociology of Religion: A Quarterly Review, 79*(4), 425–448. https://doi.org/10.1093/socrel/sry001

Travers, R., Bauer, G., Pyne, J., Bradley, K., Gale, L., & Papadimitriou, M. (2012). *Impacts of strong parental support for transgender youth.* A report prepared for Children's Aid Society of Toronto and Delisle Youth Services.

White Hughto, J. M., Rose, A. J., Pachankis, J. E., & Reisner, S. L. (2017). Barriers to gender transition-related healthcare: Identifying underserved transgender adults in Massachusetts. *Transgender Health, 2*(1), 107–118. https://doi.org/10.1089/trgh.2017.0014

Taylor & Francis
Taylor & Francis Group
http://taylorandfrancis.com

16
Helping LGBTQ Stepfamilies Meet Their Challenges

PATRICIA L. PAPERNOW

Overview

The familiar phrase "blended family" captures the hopes and wishes of new partners for loving intimacy and togetherness. However, stepfamily dynamics are often dauntingly complex and intense. Critically important, therapeutic principles applicable to first-time couples and families are not only ineffective, but all too often misleading and even destructive for most stepfamilies (Papernow, 2018). Many scholars interchangeably use the term "blended family" and "stepfamily" to describe family structures which are distinct from those of first-time families. The terms are both useful and problematic each in their own way. As umbrella terms they usefully describe families which, because they are not first-time families, share some dynamics and challenges. However, trying to simultaneously capture a large diversity of family structures also leads to oversimplifications and assumptions. For some people, "step" family members are indeed a step removed and distant, while for others "step" family members are close and connected making the term "step" feel at best unnecessary and at worst minimizing of their relationships. Similarly, the language of "blending" sows misleading expectations which can make common stepfamily challenges both surprising and shaming. In this chapter, I use stepfamilies throughout, while placing "blended family" in quotes to highlight the problematic nature of this term.

It is difficult to accurately count stepfamilies. Studies which attempt to do so have difficulty tracking the diverse and evolving forms of families. However, 26% of all marriages include stepchildren (Stykes & Guzzo, 2015) and 42% of Americans identify having a stepfamily relationship (Parker, 2011) When both married and cohabiting stepcouples are included, these rates have likely risen slightly (Guzzo, 2015). Because, currently, most LGBTQ couples are parenting children from a previous heterosexual relationship (Family Equality Council, 2017), the majority of LGBTQ-headed families are stepfamilies, sometimes called "blended families." As LGBTQ parents increasingly have children via ART (Alternative Reproductive Technologies), adoption or surrogacy, more families headed by LGBTQ couples will be first-time families (Cao et al., 2016; Family Equality Council, 2019).

The research on stepfamilies is growing exponentially, in both numbers and sophistication (Ganong & Coleman, 2017, 2018). Early stepfamily scholarship focused on *deficit comparison* research linking poorer child outcomes to stepfamily versus first-time family membership. More recent scholarship looks at processes *within* stepfamilies that support resilience. Researchers are also employing increasingly sophisticated statistical methodologies to examine these processes (Ganong & Coleman, 2018). A key finding—it is not family *structure* (first-time family versus single-parent family versus stepfamily) but family *processes* (parenting quality, conflict levels) that most robustly predict child outcomes (Dunn, 2002).

Family scholarship on LGBTQ parents, children, and families has been growing (Bos et al., 2018; Goldberg et al., 2014; Lev, 2004; Ross & Dobinson, 2013). However, research on LGBTQ

DOI: 10.4324/9780429274626-20

stepfamilies is just beginning (Ganong & Coleman, 2017), and remains focused on gay and lesbian stepcouples. Stepfamilies headed by transgender, bisexual, and queer/questioning couples remain absent from stepfamily literature. Intersections with race and ethnicity are only beginning to receive attention (Moore, 2010). LGBTQ stepcouples appear to face many of the same challenges that heterosexual cisgender stepcouples do. However, stigma and minority stress can add to these challenges for both adults and children (Bergeson et al., 2020; Papernow, 2013). Equally important, family scholars are also identifying significant strengths that appear to grow from living outside of heteronormative family structures.

Drawing on the available research combined with my own four decades of clinical experience, this chapter begins by delineating the ways in which all stepfamilies differ from first-time families. It introduces the five typical challenges stepfamily structure create for all stepfamilies and presents a three-level model for clinical work. The dynamics of each challenge are then described, noting how they may unfold similarly and differently in stepfamilies headed by LGBTQ stepcouples, as well as some of the intersections with race, ethnicity, and immigration status.

How Are Stepfamilies Different from First-Time Families?

Stepfamilies must build their lives together on a fundamentally different foundation from first-time families. First-time family couples usually enter child-rearing having had some time alone together to grow some trust and to build shared understandings about "how we do things." In a first-time family, children generally enter the adults' established relationship, one at a time. Importantly, children in first-time families usually arrive predisposed to attach to *both* of their parents and vice versa. LGBTQ couples who conceive via ART, adoption, or fostering share these first-time family characteristics (McNair, 2004). If things go well, over time, attachment throughout a first-time family becomes secure and strong. Shared habits, rituals, and values continue to grow. If the couple splits, children become part of two single-parent families. While ex-spouses do often maintain some common ground, each single-parent family usually begins to develop its own culture. In a stepfamily, a new partner enters as an *outsider* to all of these pre-existing relationships.

Stepfamilies Come in Many Forms Stepfamilies take many different forms. In what researchers call "simple" stepfamilies, only one adult brings children. In "complex" stepfamilies, both adults bring children and in either case those children may be present in the household full-time, part-time, or neither. The new couple may—or may not—go on to have another child. Because women still do more parenting than men post-divorce, lesbian stepcouples are more likely to be residential stepfamilies; gay male stepcouples are more likely to be noncustodial households (Kim & Stein, 2018). Generally, rates of unmarried cohabitation with children are rising in the United States (Parker, 2011). Thus, even though gay marriage is now legal in the United States and other countries, many LGBTQ stepcouples, like other parenting couples, remain unmarried. Stepcouples may also be fully committed but Living Apart Together (LAT) in separate residences (Benson & Coleman, 2016). Finally, U.S. divorce rates are at a 40-year low, except for those over age 50 where rates *doubled* between 1990 and 2010 (Brown & Lin, 2012). Thus, although the U.S. census counts only stepfamilies with children under 18, increasing numbers of new stepfamilies are being formed by older adults with adult children.

In addition, because LGBTQ families form outside of heteronormative Standard North American Family (SNAF) family structure, we may see even more variations. For instance, LGBTQ divorced couples may be more likely to remain more closely connected, including new partners as full members of a tightly knit family. LGBTQ youth who have been ejected from

their own families may be taken in as part of the family. A child's "other parent" outside the family may be one partner's ex-spouse, or might also be the sperm donor who helped conceive the child. All of these seemingly diverse family forms have in common that *at least one set of parent-child relationships precedes the couple relationship*. It is this fact that makes stepfamilies.

Three-Level Framework for Therapy: What, How, and Why

I use a three-level framework for clinical work (Papernow, 2013, 2018). *Psychoeducation* focuses on answering *what* is happening—identifying and sharing information about what is normal, what works, and what doesn't to meet stepfamily challenges. The second level, improving *Interpersonal Practices*, focuses on *how* this stepcouple is communicating about their challenges. Are they creating connection and understanding or disconnection and distress? Finally, *Family of Origin* work focuses on exploring *why* a particular challenge might be overwhelmingly painful for some individuals. Work on these three levels varies; some families may need psychoeducation and skills over a brief period of time, whereas others may need a deep focus on all three levels over a period of several years.

Psychoeducation (What)

Providing clear understanding of the ways that stepfamilies differ from first-time families can lift the shame of apparent failure. Evidence-informed guidance about what works, and what does not, to meet stepfamily challenges helps couples to channel their efforts much more effectively. Adults and kids in LGBTQ-headed stepfamilies also often benefit from psychoeducation about navigating minority stress and addressing internalized LGBTQ phobia.

Interpersonal Practices (How)

Family scholars find that struggling stepfamilies and successful stepfamilies face the same challenges. However, successful stepfamilies have better interpersonal skills (Stanley et al., 1999). Maintaining connection with someone who shares your point of view is considerably easier than staying empathic and caring in the face of big differences. For first-time couples, shared bonds with their children and established mutual understandings about everything from daily activities, to values, to holiday rituals create many easy channels of connection. In contrast, all five stepfamily challenges create constant differences and misunderstandings that, especially when unexpected, can trigger increasingly fraught cycles of disconnection in stepfamilies.

Family-of-Origin Work (Why)

I always start on the first two levels (what and how), providing psychoeducation and improving interpersonal connection. However, when despite this work, reactivity remains high, stepfamily challenges may be re-opening old wounds. Stepfamily living is inherently bumpy. However, some bumps prove to be especially excruciating for some people. I use "Papernow's Bruise Theory of Feelings" to de-pathologize this level of work:

> If I hit my arm in a place where the flesh is healthy, it hurts. However, if there is already a bruise there, it hurts much more. If it's a deep bruise, even a small bump can be blindingly painful.
>
> *(Papernow, 2013, p. 187)*

In these cases, healing old bruises can lower reactivity enough to meet stepfamily challenges. This is essentially individual intrapsychic work. If there is enough safety, working in the presence of the partner can significantly deepen mutual understanding. If not, I am comfortable

meeting alone with each member (Papernow, 2013). Alternatively, a referral can be made for individual therapy.

I turn now to describing the unique dynamics created by each of those five challenges, what we know about how they unfold in stepfamilies headed by LGBTQ stepcouples, and key strategies for what works, and what does not, to meet each challenge.

Five Major Challenges for Stepfamilies

The family structure inherent to stepfamilies creates five major challenges: (a) insider/outsider positions in the stepfamilies are intense, *and* stepfamily structure often keeps these positions stuck; (b) children in stepfamilies struggle with losses, loyalty binds, and the pace of change; (c) stepfamily structure often polarizes parents and stepparents around discipline and parenting; (d) stepcouples must forge a new family culture while respecting at least two previously established cultures; and (e) co-parenting after divorce is buoyed by the understanding that ex-partners are a permanent part of the family whether they are present, deceased, or estranged. These challenges mean that, for new stepcouples, fantasies of blending run into constant glitches and ruptures. Straining for immediate blending only intensifies all five challenges. Furthermore, during a major transition when kids especially need attuned adults, stepfamily structure puts both parents and stepparents at odds with children. Intersections of culture, legal systems, ethnicity, and minority stress can impact the intensity of stepfamily challenges. Family scholars are finding that lesbian stepcouples generally bring higher levels of flexibility and lower levels of reactivity to these challenges, as well as higher levels of stepfamily cohesion than their heterosexual counterparts (van Eeden-Moorefield & Pasley, 2013). In my experience, this is also true for gay stepcouples. Time usually makes a big difference in stepfamily well-being (Papernow, 2013). That said, many of these challenges continue throughout stepfamily life, although sometimes in softer form.

First Challenge: Insider and Outsider Positions

In stepfamilies, the established bonds of attachment and the (often unspoken) agreements about "how we do things" lie in pre-existing parent-child relationships, not in the stepcouple, nor in stepparent-stepchild relationships. Children in stepfamilies also generally need their parents, not their stepparents. As a result, in order to meet their children's needs, a parent must turn away from their stepparent partner. Day in and day out, when children are present, stepparents find themselves sitting on the sidelines in a *stuck outsider* position (Papernow, 2013, 2018) feeling invisible, left out, and "like I don't matter."

Parents, meanwhile, become *stuck insiders*. Parents are much more connected to their kids, to their new partner, and to their ex-partner, than stepparents are. This stuck insider position often leaves parents torn between the needs of the people who are important to them (Papernow, 2013, 2018). For parents in a stepfamily, "If my child needs me, I have to turn away from my sweetie. If my sweetie needs me, I have to turn away from my kids." This "conflict of love," as one of Moore's (2010, p. 350) lesbian stepmothers put it, can also be extremely painful and anxiety-provoking. Add ex-partners: "What keeps the peace with my ex infuriates my sweetie. And what pleases my sweetie makes conflict with my ex. And that hurts my kids."

The experience of insider-ness and outsider-ness in LGBTQ stepcouples can look and sound a lot like any other stepcouple. Stepparents say to parents, "When your kids are here, I feel like I don't exist." Parents reply, often defensively, "But they're my kids!" Stepparents protest, "But what about me!" Parents cry, "I keep trying to tell you. Don't you get it? Don't make me choose!"

For children, the parenting schedule, temperament, and age can all affect insiderness and outsiderness. Tanya (age 38) and Claire (age 37) have been together for two years. Tanya comes from a Jewish upper middle-class urban family. Claire comes from a white working-class rural

Catholic family. Tanya conceived her son Tommy (age 13) via ART in a previous lesbian relationship. Claire left a heterosexual marriage and came out a couple of years ago. Claire's daughter Ella (age 7) from that marriage lives most of the week with Claire and Tanya.

For Ella, an outgoing and engaging child, mom's household is home. Tanya's son Tommy, who is extremely shy, lives half the week with Claire and Tanya and half the week with his other mom. Shy Tommy must enter each week as an outsider to an up-and-running household where Ella's big energy naturally dominates the airwaves; add that stepfamilies are also generally easier for children eight and under like Ella, and harder for adolescents like Tommy. This combination of temperament, residency status, and age intensifies both Ella's insiderness and Tommy's outsiderness. Insider children like Ella often feel more comfortable and "at home," but they may feel intruded upon by their outsider stepsiblings. Ella says, "Every week this weird boy comes to our house. It changes everything." Outsider children often feel like strangers. Tommy sighs, "It's supposed to be my home, but it sure doesn't feel that way."

In turn, children's responses impact the adults. Ella is naturally closer to her mother (Claire) than to her stepmother (Tanya). However, Ella's young age and outgoing personality keep her stepmother feeling seen and cared about. In contrast, Tommy finds his mother's new household completely overwhelming. He can barely look at his stepmother and stepsister. Moreover, Tommy sees his own mother, Tanya, only half-time while his stepsister sees her almost full-time. Tommy says, "I *hate* watching Ella climbing all over my mama." Tommy doesn't need a "blended family." Tommy needs time alone with his mama. On his days with the family, Tommy and his mama spend a lot of time together in his room. His stepmother Claire becomes a total outsider.

Intersectionalities That Impact Insider/Outsider Positions for LGBTQ Stepcouples Many stepcouples jump into stepfamily life expecting quick "blending" only to find themselves stunned by stepfamily challenges. For LGBTQ stepcouples these challenges are aggravated by intersectional experiences of disempowerment. For example, stepcouples may be dealing with differing levels of outness. Tanya has been out since her early teens. Although her family initially struggled, their urban Jewish community supported their slow but sure move toward acceptance. Tanya also works for a gay accounting firm and has a well-established network of lesbian and gay friends. As a result, when Claire needs to turn away from Tanya to parent her daughter, Tanya has many places to turn outside their home, both in her family and in the larger community. Claire, however, came out only a couple of years ago. Her rural deeply religious Catholic family remains largely rejecting. Claire works in a Catholic school where being out would jeopardize her job. She has no connections in the gay community. When Tanya and her son are spending time together, Claire becomes a stark outsider with no place else to turn.

Immigration status also impacts this challenge, especially given the current hostile and decidedly dangerous climate in the United States, particularly for immigrants of color. Maria is a third-generation Mexican American surrounded by extended family. Although she remains closeted with most of her family, she has formed warm friendships in the lesbian community. Her partner, Sofia, is an undocumented immigrant from Mexico having fled gang violence there with her son. With fear of deportation lurking in every aspect of everyday life, even leaving the house is terrifying. When Maria attends to her two daughters, Sofia is left painfully alone, stuck at home with only her son for company.

Couples also grapple with different cultural definitions of "family." White Anglo-European culture tends to draw the line of family around the adult couple and their children. Latino, Black, and Asian families are much more likely to include grandparents and extended family, making stepparents outsiders to three generations. Andrew grew up in a white mid-Western family who cut him out of their lives after he came out to them. Soon after Andrew came out, he moved to California and formed a *chosen family* of gay friends. Andrew's partner, Ben, is Black.

For some Black gay men like Ben, being "out" means risking the loss of connection to families and communities which have nurtured, sustained, and protected them from racism. For these reasons, Ben is not out to his family and yet he remains very close to all of them, including his parents, his brothers, his uncle, and his grandmother. As a result, Andrew finds himself an outsider to an entire extended family. Andrew says:

> I haven't seen my parents in years. I completely left the area when I came out. Ben's family is completely different. His uncle lives downstairs from his mom. His gramma lives around the corner. Ben's kids lived with his gramma when the divorce got bad. He sees them *all*, *all* of the time. And, to all of them I'm just "Ben's friend." No holding hands. No inviting them over. *Ever*. It's so painful.

Strategies for Meeting Insider/Outsider Challenges: Psychoeducation Providing language for these insider/outsider positions, and empathically normalizing the intensity of the feelings they create, begins to lift the shame. I say to Claire and Tanya, "It is so painful. One of you ends up feeling left out over and over again. And the other feels torn over and over again. It's not that you don't love each other. It's because you live in a stepfamily." The divisiveness of insider/outsider positions can be particularly surprising to lesbian couples who anticipated the closeness and collaboration that often characterizes white lesbian couples (Moore, 2010). Two years into her relationship with Phoebe, Angie says, "I just assumed that we would never ever be divided by our kids! It is so helpful to have language now for this insider/outsider thing" (Papernow, 2013, p. 130).

The language of blending implies that spending time together as a family will resolve these insider/outsider challenges. Stepfamilies absolutely do need to do fun things together to build a sense of "we." However, in stepfamilies, the needs of the couple, the parent-child, and the stepparent-stepchild relationships compete with each other. Carving out alone time for each of these subsystems is critical to meeting each relationship's attachment needs.

Strategies for Meeting Insider/Outsider Challenges: Interpersonal Practices Insider/outsider challenges constantly divide parents and stepparents; at the very same moment that parents feel loved and cared about by their children, stepparents feel lonely and abandoned. In addition to normalizing the acute disappointment, we often need to teach self-regulation at moments of frustration. "Can we all take a breath here?" I also work to help couples shift complaints and criticisms into requests: "How about finishing the sentence, 'I would love it if…?'" I want to teach couples to reach out to each other at moments of vulnerability, rather than withdraw or attack. Here I am helping Tanya and Claire to listen to each other rather than to push back defensively: Claire and Tanya came to therapy for "help communicating." I start with psychoeducation about their stuck insider and outsider positions. "What's that like to hear?" I ask with each new bit of information. "A relief," Tanya says. I encourage them to turn toward each other: "Can you tell each other?" They leave holding hands. But the next session begins with Claire saying, quite sharply, to Tanya, "I can't believe you did it again!" Tanya bristles and strikes back. "What is your problem!" We begin with normalizing psychoeducation: "Oh dear," I say. "It sounds like you've hit that insider/outsider thing again."

We then turn to working on the interpersonal level, helping Tanya and Claire to hear each other across their insider/outsider divide. "I'm betting you've had this conversation before, right?" I ask. They both nod disconsolately. "Can I help you have it differently?" I use "joining" to help them slow way down (Papernow, 2016): I ask Claire to begin again, to share "just a sentence or two, the nub of what you most want Tanya to get." Claire sighs, "I just feel invisible when Tommy is here." Tanya lurches forward with, "But…" I put my hands up in a time-out sign

and step in, "Tanya, I know you love this woman. Before you respond, could you take a breath. Could you find what you DO understand about what Claire just said?" Tanya sighs. She takes a long breath. She sputters a bit before saying, "You feel *really* left out." Claire's face relaxes. Now I direct Tanya to add a sentence of her own. "He's my son," Tanya says. "This family is way too much for him." I turn back to Claire: "Now it's your turn. Can you start with what you DO understand?" We go back and forth, very very slowly, one or two sentences at a time. As they begin to hear each other, and both begin to soften, I ask them, "What's this feeling like now?" "There is a channel of connection for you here. Notice, it's not coming from agreeing. It's coming from slowing down and listening deeply." As they connect more fully, Tanya's empathy grows for Claire's outsiderness. Claire begins getting how torn Tanya feels. Closeness increases as they "both hold both."

Strategies for Meeting Insider/Outsider Challenges: Family-of-Origin Issues We have worked on the first two levels, providing psychoeducation about insiders and outsiders, and teaching some key practices to create a better connection. But Tanya and Claire keep blowing up and falling apart. Now I turn from the external to the internal, looking for old bruises from the past that might be driving reactivity: "Nobody would like feeling left out over and over again. And it looks like something about this is frying your wires. Can I tell you about Papernow's Bruise Theory of Feelings?" Then, "Who were the insiders and outsiders where you came from?"

For stuck insiders who grew up with a lot of criticism—including having been shamed for having a stigmatized core sexual or gender identity—failing to please other stepfamily members can be particularly excruciating. For stepparents who grew up with humiliation and rejection, including around their core identity as LGBTQ, stepchildren's rebuffs and partners' empathic failures may hit extra hard. Doing some individual work to heal those old bruises can free resources to meet stepfamily challenges. As a transgender stepfather said, "All through my adolescence, my father barely spoke to me. At first when my stepson wouldn't meet my eyes, it just sent me over the top." He went on to say,

> In a funny way it was a gift. It kicked my butt into some really good therapy. There were some awfully mangled little kids inside me. In therapy it's like I finally gave those hurt kids in me a chance to howl, and a chance to be heard and held. It's making all the difference.

Second Challenge: Supporting Children through Losses, Loyalty Binds, and Pace of Change

Recoupling is full of hope and excitement for the adults. Meanwhile, kids in stepfamilies are often struggling with losses, loyalty binds, and change (Papernow, 2013, 2018) as well as the impact of living in an LGBTQ family.

Losses Divorce makes lots of losses for kids: Children lose the capacity to be with both their parents at the same time. Daily life changes drastically. Divorce may require a move, resulting in lost school and friendship connections. For all children, becoming a stepfamily can add yet more loss. For example, Tommy says: It's bad enough that after the divorce I only have half time with my mom and my mama. But now when I'm with my mama, we're living in Claire's house. Claire (his stepmother) and Ella (Claire's daughter) are always there. I feel like I'm losing my mama double.

Loyalty Binds A loyalty bind means, "If I care about my stepparent, I'm disloyal to my other parent(s)." Loyalty binds also play out between a child's parents, even in friendly, collaborative divorces. However, adult conflict and tension unbearably tightens these binds for

children. When a parent comes out as LGBTQ during a divorce, the other parent's homophobia or heteronormative judgments can intensify the acrimony. Denise, now 27, was 12 when her dad moved in with Frank:

> My mom was really unhappy about being left for a guy. It was sort of like I was letting her down if I even looked at Frank. I knew he wasn't a bad person. That actually made me feel even more horrible. I've come to really love Frank. He's become a wonderful granddad to my kids. But for a long time, I was stuck between a rock and a hard place and Frank was stuck there with me.
>
> *(Papernow, 2013, p. 131)*

Pace of Change Adults in love are often eager to move in together and launch their new family. However, research tells us that for many children, the shift into a stepfamily is actually harder and takes longer than the adjustment to divorce (Ahrons, 2007). For children of newly out parents, becoming a stepfamily often coincides with coming to terms with a parent's changing sexuality or gender. However, two qualitative studies have found that when a parent comes out at divorce, the biggest challenges for kids are the adjustment to *divorce* (especially an acrimonious divorce) and the transition to *stepfamily* (Daly et al., 2015; Titlestad & Pooley, 2014). Angie's daughter puts words to this:

> [When] my mom came out to us, I didn't think about it much until she started seeing Phoebe. I think Phoebe was actually the first partner my mom was ever really in love with, including my dad. I thought that the mom I knew was gone. A year later, Phoebe and her son Philip came to live with us. Whoa! That was a lot to handle for everyone. For a while there, it was like I lost her twice triple.
>
> *(Papernow, 2013, pp. 130–131)*

As we saw earlier, age and gender influence the ease of children's adjustment to a stepfamily. Data about heterosexual, cisgender stepfamilies consistently indicate that children under nine and boys adjust more easily to stepfamilies (Ganong & Coleman, 2017; van Eeden-Moorefield & Pasley, 2013). Girls generally find the transition to stepfamily more stressful (Jensen et al., 2015), particularly early adolescent girls (van Eeden-Moorefield & Pasley, 2013). The reasons for these gender differences remain unclear, but we believe they are rooted in gender socialization and heteronormative values: Girls' sense of identity remains more closely tied to their relationships, especially in early adolescence, making changes in those relationships especially evocative.

Children of LGBTQ parents, and LGBTQ children, face the additional challenge of living in a homophobic, heterosexist cisgender culture. Children report being teased and feeling unsafe in school (Kosciw & Diaz, 2008; Welsh, 2011) with adults in authority ignoring homophobic slurs (Kuvalanka, 2012). School curricula and church teachings are often explicitly or implicitly heterosexist and homophobic (Kosciw & Diaz, 2008; Quinn et al., 2015). Adolescents are particularly sensitive to these issues (Goldberg, 2010). Sometimes younger children who had been accepting of LGBTQ parents reverse themselves as adolescents (Goldberg, 2010). Urban areas with larger LGBTQ communities are more likely to provide more acceptance and safety. However, the majority of U.S. LGBTQ families live in rural and more conservative areas (Family Equality Council, 2017) that, all too often, require constant decisions about (in)visibility. Here is Claire's daughter Ella:

> I choose my friends kinda carefully. I try to figure out who I can tell. I only bring the good ones home. It's hard keeping my family a secret. My mom and Tanya understand. It makes us all sad. But I know I can talk to them any time. That helps a *lot*.

Decades of research establish unequivocally that children of lesbian and gay parents look very similar to children with heterosexual parents (Crouch et al., 2014; Crowl et al., 2008), even scoring significantly higher on many measures (Bos et al., 2018). In fact, child outcomes for children in gay- and lesbian-headed stepfamilies are slightly better than outcomes for in stepfamilies headed by heterosexual couples (van Eeden-Moorefield & Pasley, 2013).

Strategies for Supporting Children: Psychoeducation Supporting struggling children begins with providing language for what they might be feeling. Therapists can offer children ideas of what other kids have described thinking and feeling when they were in similar situations. For example, "Sometimes when a mom finds a new partner, lots of kids feel…angry/kind of scared/lonely. Does that fit at all?" Affirmative therapy can offer children the important experience of feeling understood. Transitions which are confusing are made less overwhelming when someone else compassionately understands. The next step is to help the adults empathize.

Thus, it makes sense that one way to help kids in stepfamilies is to educate the adults about what children are feeling and needing. This is often a key focus of therapy. Do begin with empathy for the adults. "It is so hard for parents when kids struggle. More so when you've just found someone you love and your kids are unhappy!" "Can I help you understand what's happening here?" A key piece of guidance: Encourage stepcouples to carve out *both* regular couple alone time without kids *and* regular, reliable parent-child time, without stepparents and stepsiblings.

I educate stepcouples about the importance of protecting children from adult tension and "badmouthing": "Share your upset about your child's other parent with your partner, your friends, or your hairdresser. *Not the kids*." If a child's other parent is making hostile or homophobic comments, adults can acknowledge them to their children calmly and factually. "Yup. She says those things." "Sometimes people say awful things." "Some folks still have trouble that some people are gay." Then turn attention back to the child's experience. "That must make it tough for you. Any questions I can answer?"

It is important for stepcouples to keep physical intimacy private. Adults in stepfamilies often say, "I want my kids to see a positive model adult relationship." LGBTQ parents and stepparents may add, "I want the kids to know it's OK to be out and queer." Children in a first-time family usually feel supported by watching their parents cuddle, within limits. For stepchildren, however, watching their parent kiss or snuggle with a stepparent is more likely to intensify losses and magnify loyalty binds. This need to keep physical affection private can be especially painful and potentially undermining for LGBTQ couples. Living in a context where displaying affection publicly has been so laced with shame creates such eagerness and longing for open affection. I say to all stepcouples, snuggle, kiss, enjoy each other's sexuality, and look into each other's eyes. But do so with your friends and when children are not present.

In my experience, the rate at which children adjust to their parent's physical relationship with someone who is "not their parent" varies hugely. I tell all stepcouples, err in the direction of waiting longer rather than rushing this. And watch closely. If kids act out, withdraw, or get sullen, it might be too early. In my own stepfamily, after a year or two, we could easily hold hands in front of my stepsons, and occasionally give each other a quick kiss. But even in year three of our heterosexual cisgender stepcouplehood, I noticed my stepdaughter slumping in the back seat when her father and I held hands in the front seat of the car. When I asked her about it, she said, sadly, "It's just too much."

Children generally need to go *much* more slowly toward "blending" than the adults wish. For all adults who are thrilled and eager, slowing down can be extremely challenging. The long-time lack of clear rituals for LGBTQ families may add to the pressure for speedier transitions for

some (Lynch, 2000). I advise parents to wait if possible to introduce children until well beyond the early chemistry.

Some suggestions about pacing: Begin with very low-key introductions, perhaps during a neighborhood gathering. Then do a fun activity together and partner goes home. *Keep the focus on kids*, not on the new adult relationship. This reassures children that they are not losing their parent. Wise parents of very vulnerable kids may need to wait considerably longer and go much more slowly (see Bonnell & Papernow, 2019). If children are struggling and the couple has already moved in together, increasing parent-child alone time and decreasing family time often helps immensely. Going slowly is extremely challenging for all stepcouples. It may be even more so for LGBTQ couples who are desperately tired of waiting to live a fully out life.

Strategies for Supporting Children: Interpersonal Practices Therapists often need to help parents step toward their children's pain. Especially in a major transition, children's wellbeing is powerfully linked to parental attunement (Hughes, 2007). Being responsive to children's feelings, concerns, and needs eases stepfamily adjustment (Cartwright, 2010). However, because adults are so often thrilled and kids are so often not, adults often need help with this. I say to Tommy, "Tommy what do you most want your mama to get?" Tommy says, "I hate Ella" (his stepsister). His mother Tanya wants to say, "But Ella's so cute!" What Tommy needs most is to "feel felt" by his mom. I say to Tanya, "Mama, can you take a breath. Can you tell Tommy what you DO understand?" This is "joining" again (Papernow, 2016). However, unlike in the couple where joining goes two ways, here joining goes only *from* parents to kids.

It is also crucial to help children navigate stigma. Family support buffers children from stigma and bullying (Goldberg et al., 2014). Children need their LGBTQ parents and stepparents to communicate openly with them, give them a voice in who will attend what events, and allow them some choice in how much "outness" will be displayed (Goldberg, 2010). Adults support children most effectively by proactively building connections with other LGBTQ families (Green & Mitchell, 2015). LaSala (2010) and Stone Fish and Harvey (2005) are excellent resources for adults parenting LGBTQ kids.

Third Challenge: The Discipline Divide

Stepparents all over the world seem to want firmer limits with their stepchildren. Parents, including LGBTQ stepcouples (Moore, 2010), seem to want more understanding and love for their children (Nozawa, 2015; Papernow, 2013, 2015, 2018). Why? Most parents have experienced that totally in-love *and* loved feeling with their children. Parents generally understand their own children's strengths and vulnerabilities. Parents and children also share established understandings about "how we do things." Stepparents begin with none of this. In addition, stepchildren's losses and loyalty binds can make them quite rejecting of stepparents.

For all of these reasons, parents and stepparents experience the same child very differently. When this challenge goes poorly, parents and stepparents fall into escalating cycles of polarization. Stepparents complain, "Your kids are lazy/rude/careless." Parents respond, "They're just being kids." Stepparents: "You're not being tough enough." Parents: "You're over-reacting." Stepparents become increasingly harsh and demanding. Parents become ever-more protective and permissive. Off they go, doing the *Polarization Polka* (Papernow, 2013, p. 68). Meanwhile, decades of research tell us that, on every measure imaginable, children do best with author*itative* parenting. Author*itative* parenting is neither harsh nor permissive; rather, it is warm, responsive, and moderately firm (Baumrind, 1989).

Stigma and minority stress magnify this challenge. In some communities, stepcouples must make constant difficult decisions about how much to reveal and to whom. Janet Wright poignantly calls this "parenting in the mouth of the dragon" (Wright, 1998, p. 163). Many

stepcouples enter fully expecting stepparents to function like parents. For some, LGBTQ minority status deepens the longing for blending. A recoupled trans mother says: There's so much already about how "different" we are. I want us to be a family, just like any other family. It was important to me that my partner Jenny and I both called my daughters "our kids." My daughters hated it and Jenny kept saying. "I'm not their mother." But I kept correcting Jenny. Until I finally got it. It made me sad. But they were right.

In my clinical practice, LGBTQ stepcouples struggle with some of the same polarizations around discipline that heterosexual cisgender couples do. However, for many, the flexibility and creativity that accompanies living outside of societal expectations seems to soften this challenge. Lesbian and gay stepparents are less likely to expect equal parenting status and less likely to step prematurely into a disciplinary role (van Eeden-Moorefield & Pasley, 2013). Gay stepdads are more likely to cede discipline to parents (Crosbie-Burnett & Helmbrecht, 1993). It may help that, generally, gay and lesbian stepcouples more easily place children's needs ahead of adults (Lynch, 2000).

Despite the strains, jointly negotiating family visibility can strengthen family closeness (Lynch, 2000). Tanya talks about her stepfamily:

> I've been totally out for years. Tommy grew up with two mothers. Tommy and I have lots of chosen family. But Claire is still in process. She works in a Catholic school. Her kid goes to a Catholic school. Her ex-husband and most of her family think gays are sick. We had to learn how to talk about this. Now, when an event comes up, we have a family meeting. We, the adults and the kids together, decide who will go, and how much "outness" Claire and I will show. We've learned to talk about how that is for each of us. It's hard. But working this through together has definitely made us all closer and stronger.

Strategies for the Discipline Divide: Psychoeducation Substantial research provides clear direction about what works and what does not for parenting, stepparenting, and discipline in stepfamilies (see Papernow, 2019, for a five-page downloadable handout). Research consistently finds that parents need to retain the disciplinary role (Bray & Berger, 1993; Ganong & Coleman, 2017). *After* stepchildren have formed a caring trusting relationship with their stepparents, stepparents can begin to move *slowly* into authori*tative* (warm and caring, not hard and cold) discipline (Ganong & Coleman, 2017). An eventual stepparent disciplinary role is more likely with younger stepchildren. Indeed, in many thriving stepfamilies, stepparents do not have a disciplinary role (Papernow, 2013, 2018). Along with increasing one-to-one parent-child time, moving a stepparent out of a disciplinary role can sometimes make a major improvement in both children's adjustment and family well-being (Papernow, 2013).

As challenging as stepparent-stepchild relationships can be, research on stepfamilies headed by heterosexual couples is finding that they matter a lot. Both positive parent-child *and* positive stepparent-relationships reduce children's stress and increase well-being (Jensen et al., 2015, 2018). Conversely, negative stepparent-stepchild relationships are linked to poorer stepchild health (Jensen & Harris, 2017). Authoritarian (dictatorial and demanding) parenting by stepparents is toxic to stepparent-stepchild relationships (van Eeden-Moorefield & Pasley, 2013) even in cultures that value authoritarian parenting (Papernow, 2015). Healthy stepparenting begins with relationships, not rules!

Forming a caring stepparent-stepchild bond usually takes time, sometimes a lot of time. In my experience, even younger children (eight and under) with fewer losses and no major loyalty binds can require a couple of years to adjust. And, with younger kids who adjusted easily, there is often a bump of difficulty in adolescence. Adolescent girls can take as long as five years to establish a relationship with their stepfathers (Bray & Berger, 1993). Time frames are often dependent on both age and the intensity of children's losses and loyalty binds.

Strategies for the Discipline Divide: Interpersonal Practices Successful stepcouples talk a lot about parenting. Parents and stepparents can learn a lot from each other. Stepparents can often help parents to firm up; parents can often help stepparents develop more understanding of their kids. However, until stepparents have built a stepparent-stepchild relationship where discipline is possible, stepparents have *input* and parents have *final say* about their own children (Papernow, 2013). Because parents and stepparents occupy such fundamentally different positions, the key for stepcouples is often not agreement, but being able to engage over their differences with caring and respect.

With some help, Claire and Tanya have moved out of their "polarization polka" into a more "collaborative cha cha." Over breakfast, Claire takes Tanya's hand and says, "Honey, I have a request. I think Tommy is old enough to do the dinner dishes. What do you think?" Tanya sighs, "I don't know, Sweetie. He's so overwhelmed. I hate to ask any more of him." Claire: "I know. This has been tough for him." They are both quiet for a moment. Claire says, softly: "I still think we can ask a little more of him." Tanya says, sheepishly, "I do pretty much wait on him hand and foot." They both laugh. Tanya: "How about we ask him to clear the table." Claire: "Deal."

Critically important, Tanya, the parent, not Claire, the stepparent, will announce this to Tommy and monitor the follow through.

Therapists often need to help stepparents practice "connection not correction." Successful stepparent relationship-building behaviors include expressing warmth and concern, sharing fun tasks and activities, spending time without parent present, expressing empathy, and communicating constructively (Ganong et al., 2019). Stepparents can express their displeasure to stepchildren. However, successful stepparents lead with caring, not control. For example, "I'd love it if we said hello to each other" is a request for connection. "You will greet me respectfully" is an attempt at control.

Therapists can also help stepcouples engage in family conversations about navigating stigma. For queer stepcouples, life cycle, work, school, and community events may require painful choices that may not be voiced to a therapist. Children, especially adolescents, and adults may have differences over who should go, whether Mom and Stepmom should hold hands, or Dad should wear his *Gay and Proud* t-shirt to school events. Therapists can ask, "Do you talk about these things?" "How do you make these decisions?" "How does it go when you do?"

Strategies for the Discipline Divide: Family-of-Origin When, despite work on the psychoeducational and interpersonal levels, a parent or a stepparent remains stuck in harsh or permissive parenting, I ask, "What was parenting like in the family you came from?" For stepparents who grew up with dictatorial, punitive parenting, the pull toward too-much, too-early discipline is often especially strong. I can say. "Oh boy. You've got a double pull to this kind of parenting. That makes total sense. But—you might have noticed—it backfires in stepfamilies!" Likewise, parents who grew up with especially punitive, or especially permissive, parenting, may mistakenly read requests to firm up as uncaring. Stepparents with avoidant attachment are also less likely to reach out to their stepchildren (Ganong et al., 2019). For these stepparents, actively supporting attachment-seeking behavior (Hughes, 2007) is key.

Fourth Challenge: Building a New Family Culture

Becoming a stepfamily confronts all stepfamilies with a sea of differences, from what defines a messy room, to the cost of an "expensive" pair of sneakers, to how much (or whether) parents should contribute to a child's new car or college costs. Celebratory rituals that are comforting to one part of the family may prove surprisingly offensive to the other:

> It is the first Christmas together for Tanya and Claire and their children. Tanya happily hangs white lights on the Christmas tree. Claire's daughter Ella, who has been accustomed to colored bulbs, takes one look, and leaves the room sobbing.

Agreements about what feels "right" and comfortable lie in parent-child relationships, not in stepcouple or stepparent-stepchild relationships.

For LGBTQ stepcouples, these cultural differences may intersect with homophobia and racism. Andrew (42) is a white never-religious father of two. After a heterosexual marriage of ten years, he has been out for about five years. He now sees his son, though not his daughter, regularly. "I lived a charade for so many years," he says. "I want Ben and me to be out and proud. And I want us to be a family." Andrew's partner Ben (43), who is Black, has identified as gay since his 20s. Ben sees his two children often, but never with Andrew. He remains actively involved, and closeted, with his family and at his church, singing in the choir, leading a men's group, and celebrating holidays. Ben says to Andrew: "In the Black community, it's 'don't ask, don't tell'. I think my mom knows. My sister knows. We just don't talk about it. That's how we stay connected."

Andrew has replaced his own rejecting family and church with chosen family in the gay community. He wants Ben to do the same. However, for Ben, as for many Black men, church can be core to a sense of well-being which buffers the experience of racism (Quinn et al., 2015). And regular church attendance is linked to significantly higher rates of employment, educational attainment, marital stability and lower rates of incarceration (Wilcox & Wolfinger, 2016). Ben feels deeply torn between this central sustaining connection, and the cost of hiding his love for Andrew. Similarly, "familism" is a key Latino value. Familism prioritizes the needs of the family over individual needs. Combined with rigid binary conceptions of gender and Catholic stigma around divorce, Latino LGBTQ folks may experience painful pulls between family attachments and being out (Morales, 1996).

Differing Values about Money Many stepcouples find themselves facing differences in values about spending, often rooted in both ethnic and class differences. Tanya comes from an upper middle-class family where being a good parent is linked to providing well for kids. Claire's Irish working-class family values teaching children to earn their way. Tanya gives her son Tommy spending money each week. Claire requires her daughter Ella to earn her allowance. Tanya buys a new car with credit. Claire strongly prefers paying outright for a used car. Tanya earns considerably more than Claire. Like many stepcouples, Tanya and Claire manage these differences by keeping their money in separate accounts. Each pays for her own child's expenses. They contribute proportionately to an "us" account for household and vacation expenses.

Strategies for Building a New Family Culture: Psychoeducation The language of "blending" implies that becoming a stepfamily is like blending blueberries and strawberries together to make a smoothie. Therapists can empathize with the surprise and corresponding pain. I say to Ben and Andrew, "That word 'blended' didn't set you up for this, huh!" or "These differences hurt. Let's see if we can find a way to help you to understand each other." Changing the metaphor can be helpful. In fact, becoming a stepfamily is more like asking a group of Japanese and a group of Italians to live closely together. One of the implications is: Expect mistakes and missed cues. Talking things through before living together is important. However, many of our most central values have no language until someone inadvertently breaks a family rule. As a result, we often need to teach stepfamilies to expect a lot of "learning by goofing" (Papernow, 2013, p. 95). The key is to learn from mistakes, rather than attacking or despairing.

For children, familiar routines provide stability, especially at a major transition. Start with just a few new rules for everyone. Focus on those that ensure safety and civility. Families where both adults bring kids may need to live with some separate rules for a while, sometimes permanently. Claire says to Ella, "In our family, kids work for their allowance. In Tanya's family it's different. When you grow up you can decide what you think!" Tommy's mother Tanya takes responsibility for ensuring that her son doesn't flout his privilege.

Strategies for Building a New Family Culture: Interpersonal Practices Dealing with differences requires taking a breath and pulling for connection at moments that pull for attack or withdrawal. Tanya needed help shifting from, "Christmas is ruined," to "Ooops. Looks like I just learned something, Ella, about you and Christmas." Basic skills like "I messages" and making requests rather than criticisms enable couples to bring up fraught subjects in ways that support connection: "I'd love it if…" rather than, "What's your problem with…"

Tanya and Claire embraced these skills wholeheartedly and fairly quickly. Ben and Andrew struggled mightily. Levels of avoidance are high in all stepcouples (Halford et al., 2007), and especially in gay male couples (Green & Mitchell, 2015). Helping Ben and Andrew connect sometimes felt tortuous. Ben says, "Man, try to imagine what it's like to be a Black man living in a world that treats you like trash in a million small and large ways." He pauses. "Andrew, my family and my church are my sanctuary. They're my blood and my bones. Without them a Black man is garbage." Andrew tenses visibly. I help Andrew take a breath and hang in. "Can you tell Ben what you DO get?" Ben begins to feel received. He looks moved. "Ben, OK can you tell Andrew how this feels right now?" Slowly, slowly, a few sentences at a time they begin to empathize across this chasm of differences.

Fifth Challenge: Post Divorce Co-Parenting

Decades of research firmly establish that children from high-conflict never-divorced households do significantly more poorly than those with low-conflict divorced parents (Amato & Afifi, 2006). Meeting the challenge of cooperative post-divorce parenting has some extra twists for LGBTQ stepfamilies.[1]

Stepfamilies that begin with a divorced LGBTQ couple must navigate a complex minefield. For instance, asset division and spousal support for lower-earning partners are usually tied to marriage length. Many LGBTQ couples have had long, committed relationships that preceded the legalization of gay marriage with *Obergefell v. Hodges* in 2015. Some judges include these years in a divorce settlement. Others do not (Kim & Stein, 2018), substantially impacting the financial well-being of the next relationship.

Co-parenting after divorce is buoyed by the understanding that ex-partners are a permanent part of the family. How ex-partners interact, co-parent, or integrate family time can vary widely depending on the nature of the relationships before the divorce and current relational capacity and process. Affirmative therapists can help families create post-divorce family structures which honor their unique circumstance. This is especially important because LGBTQ parents and stepparents remain vulnerable in divorce to losing not only custody but even the right to regular visitation (Maolemi, 2018). Legal avenues to adoption for LGBTQ non-biological parents remain extremely inconsistent (Chauveron et al., 2016; Farr & Goldberg, 2018). The higher a parent's involvement in pre-divorce child-rearing, the more critical post-divorce parent-child contact is (Poortman, 2018). However, even fully engaged non-biological LGBTQ parents remain vulnerable to losing custody (Maolemi, 2018), particularly trans parents (Family Equality Council, 2017).

Divorcing lesbian couples are generally less prone to conflict over custody (Kim & Stein, 2018), especially when both co-mothers have adopted their child(ren) (Gartrell et al., 2011). However, Phoebe's story highlights the vulnerability. Phoebe and her first partner, Barb, had separated before the *Obergefell* case. During their ten-year relationship, they had adopted and raised their son Philip. Because they had to use a religious organization that disqualified lesbian couples, one of them, Barb, completed the adoption process as if she were a single parent. They

[1] "Divorce" will be used here to cover both legal divorce after marriage and a parental split after cohabitation.

had "just never gotten around to" completing legal adoption papers for status Phoebe and Philip. Four years after their split, Barb was still sending nasty emails citing Phoebe's lack of legal in her threats to cut off Phoebe's contact with Philip (Papernow, 2013). Phoebe continues:

> I think Barb was terrified of losing Philip to [Phoebe's new partner] Angie. I get it. But poor Philip was caught in the middle. That made him *real* distant with Angie, which was hard on her. And us. I still spend most of the time with Philip alone, without Angie. That is so tough, but it keeps Barb calmer. And that's best for Philip. And us.

For some heterosexual ex-partners, being left for an LGBTQ adult adds to the acrimony. This was true for Denise, who we met earlier. In contrast, Angie and her ex-husband Mike had always been friends and continued to be. "I actually think Mike knew before I did that I was just not a straight woman. But since he hadn't lost me to another guy, he said it was easier to continue being friends, just like we always were" (Papernow, 2013, p. 134). This kind of collaborative ex-partner co-parenting is infinitely better for children. As with heterosexual stepcouples, however, it can be challenging for new partners. Angie's partner Phoebe says, "I had to get used to Mike being part of our family."

Strategies for Post-Divorce Co-Parenting: Psychoeducation Cooperative post-divorce co-parenting is best for children. Low conflict *parallel parenting*, where households function separately but respectfully, is more common and still protective (White & Gilbreth, 2001). For high-conflict ex-partners, explicit agreements and rigid visitation schedules help create minimal need for coordination between households (Lebow, 2015). Protecting children from adult conflict is critical to their well-being. I often tell supervisees that we need to educate, monitor, and intervene concerning parental conflict with the same attention that physicians monitor blood pressure (Papernow, 2013).

We need to educate clients that parenting is not a zero-sum game**:** Positive relationships with *both* parents and with *both* stepparents in *both* households make the healthiest children (King, 2009). Help nonresidential parents stay engaged with texts, birthday cards, and short notes. Partners can also help. Andrew complains, "My daughter never returns my calls or emails." His partner Ben says, "Then text her. Teens don't email or call. They text and Instagram! Text her! Instagram her."

Strategies for Post-Divorce Co-Parenting: Interpersonal Practices On behalf of children, we often need to teach ex-partners to use their best skills in situations that trigger their worst. I teach clients to respond to provocative emails with short factual responses. "I'm so sorry. I can't switch weekends with you." I also Conduct highly structured meetings with ex-partners centered on child issues and/or develop collaborative relationships with LGBTQ affirmative co-parenting coaches and mediators who are trained to do this well.

Therapy with Stepfamilies: Some General Guidelines

Family Therapy in Subsystems

In stepfamilies, meeting attachment needs in one subsystem (couple, parent-child, stepparent-stepchild) often leaves another family member feeling (and being) deserted. For this reason, beginning family therapy with a whole stepfamily in the room is usually counter-productive and often even damaging. It is essential to *think* systemically (hold the stories of all family members in your own heart). However, *work* in subsystems. Focus initially on strengthening the sense of feeling heard and understood in the adult couple, in parent-child relationships,

and perhaps among siblings and stepsiblings. When attachment is more secure in couple and parent-child relationships, family work becomes possible. Unless the stepparent is a major source of support for children, save stepparent-stepchild relationships for after parent-child and couple relationships have been solidified. Work to lower tension in ex-partner relationships. If the latter is not your forte, refer to an LGBTQ-affirmative mediator or post-divorce co-parenting coach

When more than one clinician is involved, close collaboration between treating therapists is vital. The more a stepfamily is struggling, the more likely that each member will be able to tell only their own story of pain, demonizing others in the system. The pull for individual therapists to join with the demonizing narrative can be powerful, and destructive, inhibiting the central task of deepening empathy and connection across the divides stepfamily challenges create.

When Psychoeducation Meets Shame and Grief

Some stepcouples are extremely relieved to trade the high expectations of blending families for realistic guidance about what works. However, for many stepcouples, giving up the expectation of an immediately loving new family is deeply disappointing. Add that corrective information always risks being inadvertently shaming—"How dumb of me that I didn't know that." Check frequently, "What's that like to hear from me?" When clients seem "resistant," slow down. Take a breath. Look for what you do understand. "Of course, you would like your partner to love your son the way you do. What parent wouldn't want that?" Stay there until you see some softening. Then try again, gently. "Bummer that stepparenting and parenting are so different." The "language of wishing" can help access deep pockets of grief that often lie under resistance. "You so wish your partner could feel the same way about your son that you do."

Guidelines for Healing Old Bruises

Because stepfamily challenges create such intense feelings, therapists may be drawn to start on the intrapsychic level. However, it is much more respectful and effective to start with psychoeducation and building better interpersonal connections. *Then*, if emotional reactivity remains high, begin turning inward toward family-of-origin wounds. The clue to shift levels is often a continuous looping, "we've been over this before" feeling. This was true for Ben and Andrew.

Over several sessions, Ben and Andrew would begin to soften and connect. Then, suddenly, one of them would shut down or attack. I began asking each of them, "What just happened inside?" Finally, Andrew began telling a heartbreaking story of learning to hold his own in a critical, shaming, homophobic family where exposure of any kind was toxic and dangerous. He teared up, looking down and away. I said, gently but firmly,

> Andrew, I know where you came from this was terrifying. And you were so alone. I wonder, would you be willing to look at Ben. Maybe just out of the corner of your eye, look and see what you see.

"Acceptance," he replied softly." I said: "How about just noticing that for a while." "Ben, what's it like to feel Andrew share with you this way?" Ben said: "Man, it pulls me so close to you."

The challenges of stepfamilies can create feelings that make the sanest of us feel quite nutty. When humiliation, shame, and rejection have been so woven into the story, as they so often are for LGBTQ folks, it is *especially* critical to begin the invitation to turn inside by first acknowledging the very real power of stepfamily dynamics. "Nobody would like this. To have another person ignore you, up close and personal, is painful for all humans…AND this seems to be taking your wise mind clear offline, right when you need it!"

Proactively Build Chosen Family

LGBTQ stepcouples are sometimes triply stigmatized (Berger, 2000). They are queer in a heterosexist SNAF-centric culture. They may be parents among child-free LGBTQ friends. And they are a stepfamily in a first-time family-centered world. This can make finding a community of folks who "get it" especially challenging. Help clients clearly define who and where their systems of support are. Proactively and deliberately creating "an integrated social support system that has family-like qualities" is part of the work (Green & Mitchell, 2015, p. 502).

Becoming a Stepfamily Is a Process Not an Event

Becoming a stepfamily takes years, not months. As one mom said to me, "It's a slow cooker. It ain't fast food." After a hard start, here is Anna, daughter to Angie, stepdaughter to Phoebe, two and half years later. (Notice that Mom has instituted mother-daughter time.)

> Things got much better. My mom went back to being my mom. Now she takes me to school every day. That's our time. Having Phoebe in our family is starting to feel kind of good… my mom wouldn't be caught dead in a shopping mall or getting a manicure. Phoebe *loves* to shop, and she is teaching me how to do a French manicure. Phoebe is all right.
>
> *(Papernow, 2013, p. 131)*

Conclusion

Currently, although it is rarely noted by family scholars, the majority of LGBTQ-headed families are stepfamilies. LGBTQ stepcouples, like their heterosexual, cisgender counterparts, often face some daunting challenges. These include painfully stuck insider/outsider positions, struggling children, divisions over parenting, differences in how things are done and fraught ex-partner relationships. LGBTQ stepfamilies must also navigate the challenges of living in a heteronormative, homophobic, SNAF-centered culture.

Key strategies for meeting stepfamily challenges include naming, normalizing, and deepening mutual empathy for insider/outsider positions, helping adults to understand and empathize with children's struggles, spending fun time as a family while also carving out one-to-one time to support attachment in the couple, in parent-child relationships, and in stepparent-stepchild relationships, leaving parents in control of discipline while helping stepparents focus on connection and relationship development, beginning to slowly build a new "we" while honoring existing family cultures, and protecting children from adult conflict. For LGBTQ stepfamilies proactively building "chosen family," engaging in family conversation about stigma, and giving children a voice in decisions about exposure and disclosure are also key. While minority stress can add to the challenges, the flexibility and creativity that accompanies living outside of societal expectations also brings many strengths that foster thriving LGBTQ stepfamily relationships.

References

Ahrons, C. R. (2007). Family ties after divorce: Long-term implications for children. *Family Process, 46*(1), 53–65. https://doi.org/10.1111/j.1545-5300.2006.00191.x

Amato, P. R., & Afifi, T. D. (2006). Feeling caught between parents: Adult children's relations with parents and subjective well-being. *Journal of Marriage and Family, 68*(1), 222–235. https://doi.org/10.1111/j.1741-3737.2006.00243.x

Baumrind, D. (1989). Rearing competent children. In W. Damon (Ed.), *Child development today and tomorrow* (pp. 349–378). Jossey-Bass.

Benson, J. J., & Coleman, M. (2016). Older adults living apart together. *Journal of Marriage and Family, 78*(3), 797–812. https://doi.org/10.1111/jomf.12292

Berger, R. (2000). Gay stepfamilies: A triple-stigmatized group. *Families in Society: The Journal of Contemporary Human Services, 81*(5), 504–516. https://doi.org/10.1606/1044-3894.1052

Bergeson, C., Bermea, A., Bible, J., Matera, K., van Eeden-Moorefield, B., & Jushak, M. (2020). Pathways to successful queer stepfamily formation. *Journal of GLBT Family Studies, 16*(4), 368–384. https://doi.org/10.1080/1550428X.2019.1673866

Bonnell, K. S., & Papernow, P. L. (2019). *The stepfamily handbook: From dating, to getting serious to forming a "blended family."* CMC Publishers.

Bos, H. M. W., Kuyper, L., & Gartrell, N. (2018). A population-based comparison of female and male same-sex parent and different-sex parent household. *Family Process, 87*(1), 148–164. https://doi.org/10.1111/famp.12278

Bray, J., & Berger, S. H. (1993). Developmental issues in stepfamilies research project: Family relationships and parent-child interactions. *Journal of Family Psychology, 7*(1), 76–90. https://doi.org/10.1037/0893-3200.7.1.76

Brown, S. L., & Lin, I. F. (2012). The gray divorce revolution: Rising divorce among middle-aged and older adults, 1990–2010. *The Journals of Gerontology Series B: Psychological Sciences and Social Sciences, 67*(6), 731–741. https://doi.org/10.1093/geronb/gbs089

Cao, H., Mill-Koonce, R. W., Wood, C., & Fine, M. (2016). Identity transformation during the transition to parenthood among same-sex couples: An ecological, stress-strategy-adaptation perspective. *Journal of Family Theory & Review, 8*(1), 30–59. https://doi.org/10.1111/jftr.12124

Cartwright, C. (2010). Preparing to re-partner and live in a stepfamily: An exploratory investigation. *Journal of Family Studies, 16,* 237–250. https://doi.org/10.5172/jfs.16.3.237

Chauveron, L. M., Alvarez, A., & van Eeden-Moorefield, B. (2016). The co-evolution of marriage and parental rights of gays and lesbians. *Journal of GLBT Family Issues, 13*(2), 114–136. https://doi.org/10.1080/1550428X.2016.1187105

Crosbie-Burnett, M., & Helmbrecht, L. (1993). A descriptive empirical study of gay male stepfamilies. *Family Relations, 42*, 256–262. https://doi.org/10.2307/585554

Crouch, S. M., Waters, E., McNair, R., Power, J., & Davis, E. (2014). Parent-reported measures of child health and wellbeing in same-sex parent families: A cross-sectional survey. *BMC Public Health, 14*, 635. https://doi.org/10.1186/1471-2458-14-635

Crowl, A., Ahn, S., & Baker, J. (2008). A meta-analysis of developmental outcomes for children of same-sex and heterosexual parents. *Journal of GLBT Family Studies, 4*(3), 385–407. https://doi.org/10.1080/15504280802177615

Daly, S. C., MacNeela, P., & Sarma, K. M. (2015). When parents separate and one parent 'comes out' as lesbian, gay or bisexual: Sons and daughters engage with the tension that occurs when their family unit changes. *PLOS ONE, 11*(3), e0151120. https://doi.org/10.1371/journal.pone.0151120

Dunn, J. (2002). The adjustment of children in stepfamilies: Lessons from community studies. *Child & Adolescent Mental Health, 7*(4), 154–161. https://doi.org/10.1111/1475-3588.00028

Family Equality Council. (2017). *LGBTQ family fact sheet.* https://www2.census.gov/cac/nac/meetings/2017-11/LGBTQ-families-factsheet.pdf

Family Equality Council. (2019). *LGBTQ family building survey.* https://www.familyequality.org/resources/lgbtq-family-building-survey/

Farr, R. H., & Goldberg, A. E. (2018). Sexual orientation, gender identity, and adoption law. *Family Court Review, 56*(3), 374–383. https://doi.org/10.1111/fcre.12354

Ganong, L., & Coleman, M. (2017). *Stepfamily relationships: Development, dynamics, and interventions* (2nd ed.). Springer. https://doi.org/10.1007/978-1-4899-7702-1

Ganong, L., & Coleman, M. (2018). Studying stepfamilies: Four eras of family scholarship. *Family Process, 57*(1), 7–24. https://doi.org/10.1111/famp.12307

Ganong, L., Jensen, T., Sanner, C., Russell, L., & Coleman, M. (2019). Stepfathers' affinity-seeking with stepchildren, stepfather-stepchild relationship quality, marital quality, and stepfamily cohesion among stepfathers and mothers. *Journal of Family Psychology, 33*(5), 521–531. https://doi.org/10.1037/fam0000518

Gartrell, N., Bos, H., Peyser, H. Deck, A., & Rodas, C. (2011). Family characteristics, custody arrangements, and adolescent psychological wellbeing after lesbian mothers break up. *Family Relations, 60*(5), 572–585. https://doi.org/10.1111/j.1741-3729.2011.00667.x

Goldberg, A. E. (2010). *Lesbian and gay parents and their children: Research on the family life cycle*. American Psychological Association. https://doi.org/10.1037/12055-000

Goldberg, A. E., Gartrell, N. K., & Gates, G. (2014). *Research report on LGB families.* The Williams Institute. https://williamsinstitute.law.ucla.edu/publications/report-lgb-parent-families/

Green, R. -J., & Mitchell, V. (2015). Gay, lesbian, and bisexual issues in couple therapy. In A. Gurman, J. Lebow, & D. Snyder (Eds.), *Clinical handbook of couple therapy* (5th ed., pp. 489–511). Guilford.

Guzzo, K. B. (2015). *Shifts in higher-order unions and stepfamilies among currently cohabiting and married women of childbearing age.* The Center for Family and Demographic Research. https://doi.org/10.1177/0192513X16664180

Halford, K., Nicholson, J., & Sanders, M. (2007). Couple communication in stepfamilies. *Family Process, 46*(4), 471–483. https://doi.org/10.1111/j.1545-5300.2007.00226.x

Hughes, D. (2007). *Attachment focused family therapy.* Norton.

Jensen, T. M., & Harris, K. M. (2017). Longitudinal analysis of stepfamily relationship quality and adolescent health. *Journal of Adolescent Health, 61*(4), 486–492. https://doi.org/10.1016/j.jadohealth.2017.04.015

Jensen, T. M., Lippold, M., Mills-Koonce, R., & Fosco, G. (2018). Stepfamily relationship quality and children's internalizing and externalizing problems. *Family Process, 57*(2), 477–495. https://doi.org/10.1111/famp.12284

Jensen, T. M., Shafer, K., & Holmes, E. K. (2015). Transitioning to stepfamily life: The influence of closeness with biological parents and stepparents on children's stress. *Child and Family Social Work, 22*(1), 275–286. https://doi.org/10.1111/cfs.12237

Kim, S. A., & Stein, E. (2018). Gender in the context of same-sex divorce and relationship dissolution. *Family Court Review, 56*(3), 384–398. https://doi.org/10.1111/fcre.12355

King, V. (2009). Stepfamily formation: Implications for adolescent ties to mothers, nonresident fathers, and stepfathers. *Journal of Marriage and Family, 71*(4), 954–968. https://doi.org/10.1111/j.1741-3737.2009.00646.x

Kosciw, J. G., & Diaz, E. M. (2008). *Involved, invisible, ignored: The experience of lesbian, gay, bisexual, and transgender parents and their children in our nation's K-12 schools.* Gay, Lesbian and Straight Education Network. https://eric.ed.gov/?id=ED500474

Kuvalanka, K. A. (2012). The kids might be all right, but some might still end up in your office: Working with children of LGBTQ parents. In J. J. Bigner & J. L. Wetchler (Eds), *Handbook of LGBT-affirmative couple and family therapy* (pp. 167–182). Routledge.

LaSala, M. (2010). *Coming out, coming home*: *helping families adjust to a gay or lesbian child.* Columbia University.

Lebow, J. (2015). Separation and divorce issues in family therapy. In A. Gurman, J. Lebow, & D. Snyder (Eds.), *Clinical handbook of couple therapy* (5th ed., pp. 445–466). Guilford.

Lev, A. I. (2004). *Transgender emergence: Therapeutic guidelines for working with gender-variant people and their families*. Routledge.

Lynch, J. (2000). Considerations of family structure and gender composition: The lesbian and gay stepfamily. *Journal of Homosexuality, 40*(2), 81–95. https://doi.org/10.1300/J082v40n02_06

Maolemi, L. (2018). Blood will not justify: Same-sex couples and their battle for standing as de facto parents. *Family Court Review, 56*(3), 490–505. https://doi.org/10.1111/fcre.12367

McNair, R. (2004). *Outcomes for children born of A.R.T. for a diverse range of families.* Victorian Law Commission. https://www.lawreform.vic.gov.au/sites/default/files/OutcomesforChildrenBornofARTinaDiverseRangeofFamiliesOccasionalPaper.pdf

Moore, M. R. (2010). Gendered power relations among women: A study of household decision making in Black, lesbian stepfamilies. *American Sociological Review, 73*(2), 335–356. https://doi.org/10.1177/000312240807300208

Morales, E. (1996). Gender roles among Latino gay and bisexual men: Implications for family and couple relationships. In J. Lair & R. J. Green (Eds.), *Lesbians and gays in couples and families* (pp. 272–297). Jossey-Bass.

Nozawa, S. (2015). Remarriage and stepfamilies. In S. R. Quah (Ed.), *The Routledge handbook of families in Asia* (pp. 345–358). Routledge.

Papernow, P. L. (2013). *Surviving and thriving in stepfamily relationships: What works and what doesn't.* Routledge.

Papernow, P. L. (2015). Introduction to the Japanese translation: What is similar and what is different about Japanese stepfamilies? In S. Nakamura, M. Ohnishi, & Y. Yoshikawa (Trans.), *Suteppu famiri wo ikani iki, hagukumuka: Umakuikukoto ikanaikoto.* [*Surviving and thriving in stepfamily relationships: What works and what doesn't?* (pp. iii–ix). Kongo Shuppan.

Papernow, P. L. (2016). Empathic joining. In G. R. Weeks, S. T. Fife, & C. M. Peterson (Eds.), *Techniques for the couple therapist: Essential interventions from the experts* (pp. 137–141). Routledge. https://doi.org/10.4324/9781315747330-29

Papernow, P. L. (2018). Clinical guidelines for working with stepfamilies: What individual, couple, child, and family therapists need to know. *Family Process, 57*(1), 25–51. https://doi.org/10.1111/famp.12321

Papernow, P. L. (2019). Ask the experts: A baker's dozen tips for parenting, stepparenting, and discipline in stepfamilies. *Association of Family and Conciliation Courts eNews, 14*(6), 1–5. https://files.constantcontact.com/6beb60a3701/c490079a-389a-4be9-8615-d7ba77b9fbe2.pdf

Parker, K. (2011). A portrait of stepfamilies. *Pew Social & Demographic Trends.* https://www.pewsocialtrends.org/2011/01/13/a-portrait-of-stepfamilies/

Poortman, A. -R. (2018). Postdivorce parent-child contact and child well-being: The importance of predivorce parental involvement. *Journal of Marriage and Family, 80*(3), 684–703. https://doi.org/10.1111/jomf.12474

Quinn, K., Dickson-Gomez, J., & Kelly, J. A. (2015). The role of the Black church in the lives of young Black men who have sex with men. *Culture, Health, and Sexuality, 18*(5), 524–537. https://doi.org/10.1080/13691058.2015.1091509

Ross, L. E., & Dobinson, C. (2013). Where is the "B" in LGBT parenting? A call for research on bisexual parenting. In A. E. Goldberg & K. R. Allen (Eds.), *LGBT-parent families: Innovations in research and implications for practice* (pp. 87–103). Springer Science + Business Media. https://doi.org/10.1007/978-1-4614-4556-2_6

Stanley, S. M., Blumberg, S. L., & Markman, H. J. (1999). Helping couples fight for their marriages. In R. Berger & M. T. Hannah (Eds.), *Preventive approaches in couples therapy* (pp. 279–303). Brunner/Mazel.

Stone Fish, L., & Harvey, R. G. (2005). *Nurturing queer youth.* Norton.

Stykes, B., & Guzzo, K. B. (2015). *Remarriage and stepfamilies* (FP-15-10). National Center for Family & Marriage Research. https://www.bgsu.edu/content/dam/BGSU/college-of-arts-and-sciences/NCFMR/documents/FP/stykes-guzzo-remarriage-stepfamilies-fp-15-10.pdf

Titlestad, A., & Pooley, J. A. (2014). Resilience in same-sex parented families: The lived experience of adults with gay, lesbian, or bisexual parents. *Journal of GLBT Family Studies, 10*(4), 329–353. https://doi.org/10.1080/1550428X.2013.833065

van Eeden-Moorefield, B., & Pasley, B. K. (2013). Remarriage and stepfamily life. In G. W. Peterson & K. R. Bush (Eds.), *Handbook of marriage and the family* (3rd ed., pp. 517–546). Springer. https://doi.org/10.1007/978-1-4614-3987-5_22

Welsh, M. G. (2011). Growing up in a same-sex parented family: The adolescent voice of experience. *Journal of GLBT Family Studies, 7*(1–2), 49–71. https://doi.org/10.1080/1550428X.2010.537241

White, L., & Gilbreth, J. G. (2001). When children have two fathers: Effects of relationships with stepfathers and noncustodial fathers on adolescent outcomes. *Journal of Marriage and Family, 63*(1), 155–167. https://doi.org/10.1111/j.1741-3737.2001.00155.x

Wilcox, W. B., & Wolfinger, N. H. (2016). *Soul mates: Religion, sex, love, and marriage among African Americans and Latinos.* Oxford University Press. https://doi.org/10.1093/acprof:oso/9780195394221.001.0001

Wright, J. M. (1998). *Lesbian step families: An ethnography of love.* Routledge.

17
"I Will Always Come Home to You"
Affirmative Therapy with Clients Practicing Consensual Non-Monogamy

SHEILA M. ADDISON and NOELLE CLASON

The couple came into my (SA's) office already on edge with one another. Layla, an Arab-American transgender woman, had clearly been crying and was on the verge of doing so again. Her husband Mike, a worried-looking white cisgender man, carried a manila folder under his arm, from which he produced a stack of articles obviously printed out from the Internet. Before even introducing himself, he laid the articles out on my coffee table, holding my eye contact meaningfully. He had given me few details over the phone, other than to say that he and Layla needed "help with our marriage," and to make sure I had experience working with transgender clients and their partners, but as I began the intake interview, it became clear that Mike wanted to open the marriage up to other sexual partners, but Layla definitely did not.

I chose not to acknowledge the printouts for the time being, which clearly began to bother Mike as our session went on. He gestured toward them several times as he made his case for why non-monogamy was the right direction for them: resisting the norms of "traditional" marriage; allowing for sexual variety; acknowledging that no one person can possibly meet all of their partner's social, emotional, intellectual, and sexual needs. I nodded, reflected his perspective to check my understanding, and validated his desire for a relationship that he believed would be more exciting and fulfilling. Mike relaxed a little.

But I also encouraged Layla to talk about her perspective: her worry that she would come to represent all of the day-to-day chores and issues at home while other partners would get the fun, romantic Mike from when they first dated; her fears of dating as a transgender woman of color; her fear that Mike would leave her for another woman when he met someone "more exciting." As I reflected and validated her concerns, Mike grew restless and I saw his gaze shift to his printouts more than a few times.

Toward the end of our session, I steered the topic toward goal setting, asking the couple "how will you know when you got what you came here for? What will be different?" and "what would make you say 'I'm really glad we did that therapy together'?"[1] Mike described a future in which the two of them dated others regularly and were part of the local polyamorous community. Layla described the two of them having sex more regularly and doing more fun things together as a couple. Although their visions seemed fairly disparate, I summarized what I thought might be a mutual goal: "So, both of you want to enjoy your marriage more, even if you have different ideas about how that might happen." Layla nodded, looking hopeful, but Mike frowned. "I don't want to enjoy it," he objected, pushing his articles toward me. "I want it to EVOLVE." And now I could clearly see the title of one of the articles: "Polyamory: The Next Stage in Human Evolution."

[1] Questions for which I am indebted to the work of Insoo Kim-Berg, even though I am not, as such, a Brief Solution-Focused Therapist.

DOI: 10.4324/9780429274626-21

The following week, Layla returned to therapy alone. Mike had given her an ultimatum: he wanted to start dating others. She had moved out, wanted a separation, and wondered if I could be her individual therapist instead of their couple counselor. "Mike said he didn't want to come back because it wouldn't help. He thought you could make me see his point of view but it's just not for me." And so, began, and ended, my first case of working with a couple on the issue of consensual non-monogamy (CNM).

Although I did not advertise myself as a specialist in this area for many more years, clients would continue to seek me out for help because I advertised to the LGBTQ+ community, assuming, I suppose, that comfort with what some referred to as "alternative lifestyles"[2] meant I could be trusted not to pathologize them for wanting a non-monogamous relationship. And, although the majority of the clients who sought my help with non-monogamy were heterosexual and cisgender, many of my queer and trans clients also practiced some form of CNM, so to serve them effectively as an affirming therapist, I needed to be able to affirm their multiple and varied relationships as well.

When the first edition of this handbook was published in 2012 (Bigner & Wetchler, 2012), there were no entries in the index for *monogamy, non-monogamy, polyamory, sexual fidelity, multiple relationships*, or even *affairs*. And yet, therapists working with gay and lesbian clients have observed for decades that these groups are more likely to be non-monogamous than heterosexuals (e.g., Kassoff 1989; Shernoff, 1995). It makes sense, then, that relational therapists working with LGBTQ+ clients should have a working knowledge of how to address the needs of clients who practice CNM.[3] In this chapter, we provide an overview of CNM relationships, specifically looking at their appeal to LGBTQ+ clients, guidelines for affirming practice, and common clinical presentations in relational therapy.

Prevalence

In the United States and Canada, over 20% of single adults report having engaged in CNM at some point in their lives (Fairbrother et al., 2019; Haupert et al., 2016). While prevalence is difficult to capture accurately, the 2012 National Survey of Sexual Health and Behavior estimates about 4% of Americans are currently in a CNM relationship (Levine et al., 2018), but queer and trans participants were more likely than straight or cis participants to report doing so. While the image of life-long or serial monogamy with "the one" perfect partner is still very much held up as the ideal in the West, a phenomenon some call "compulsory monogamy" (Ritchie & Barker, 2006, p. 587), general interest in non-monogamy has increased dramatically over the past decade (Moors, 2016). Members of cultural, sexual, and geographic subcultures, including queer and trans communities, may even feel pressured to adopt a kind of "compulsory non-monogamy" in response to in-group norms (Sheff, 2018).

Estimates of CNM relationships in gay male couples typically find around a third report being non-monogamous; Levine et al. (2018) put the prevalence at 32%. Tunnell (2012) notes that the assumption that most gay couples are non-monogamous means that many regularly receive invitations for sex from other men, and thus have to regularly assert their boundaries. For those who are non-monogamous, negotiation of and fidelity to agreements about safer sex practices remain a critical part of gay couples' extra-relationship sexual encounters; happily,

[2] And what queer and trans people just referred to as "our lives."

[3] An umbrella term rather like "queer," CNM includes a variety of relationship styles, such as open relationships, "swinging," polyamory, and relationship anarchy. The common thread is that multiple sexual and/or romantic connections are pursued with the knowledge and consent of all involved, contrasted with "non-consensual non-monogamy," or "infidelity." Some have proposed the term "ethical non-monogamy," but we have at times witnessed some rather inconsistent or incoherent ethics practiced by clients, so the term seems more aspirational than descriptive. Because the consent of all parties involved is the common factor across different approaches to non-monogamy, it makes sense to us to emphasize that aspect.

CNM is associated with more frequent testing for sexually transmitted infections and more condom use overall, particularly for anal sex (Levine et al., 2018).[4]

Although most research indicates that lesbians are less likely to identify being in a CNM relationship than gay men, they are still slightly more non-monogamous than the general population—5% according to Levine et al. (2018).[5] While some lesbian couples may use CNM as a way to reduce their alleged tendency to "merge" as a dyad, Kassoff (1989) suggests that it can serve a variety of functions, including enriching the sexual dimension of a primary relationship as an expression of feminist relational ethics, or as a way of establishing an individuated self as one's primary concern, rather than giving in to the cultural expectation of couplehood.

Levine et al. (2018) found that 22% of self-identified bisexuals reported being in CNM relationships, even though when they do so, they risk playing into the stereotype that conflates bisexuality with hypersexuality: being "promiscuous, deceptive, and unable to commit to long-term relationships" due to a desire for partners of more than one gender (McLean, 2004, p. 85). However, Weitzman (2007) found that 70% of a sample of polyamorous bisexuals reported their partners' gender did not matter to them, and only 12% said their interest in CNM was mainly due to wanting more than one gender of partner. McLean (2004) found that many bisexuals reported that their different-gender partner wanted them to *only* take lovers of other genders, different from the partner.

Levine et al. (2018) found that about 13% of transgender respondents were involved in CNM relationships. However, as with most aspects of transgender people's intimate and sexual relationships, their experiences of CNM remain largely unexplored.[6] Malpas (2012) hints delicately at the "sophisticated arrangements" (p. 75) negotiated by some couples when one partner transitions, and later overtly suggests that when a couple wants to stay together but the cisgender partner is not bisexual, CNM may provide a way for both to get their sexual needs met. Another virtue of CNM, Malpas (2006) points out, is that it can accommodate genderqueer or genderfluid partners who want to experience their gender differently in the context of different sexual and romantic relationships.

Special Vocabulary for Special Relationships

Clinicians working with LGBTQ+ clients should already be familiar with the way marginalized groups' language for describing themselves can change over time.[7] Terms may vary regionally and internationally, even among English speakers; multiply marginalized groups, like non-monogamous queer and transgender people of color (QTPOC), may also have their own indigenous usages. Clinicians should also expect that terms can vary over time or by age cohort. Even as we attempt to define terms currently in circulation, we advise clinicians to adopt a stance of cultural humility (Vaughan et al., 2019), valuing clients' expertise, and being willing to both ask good questions and receive corrections.

Styles of CNM

Here, we will try to clarify different approaches to CNM, but we advise clinicians to always adopt a curious, not-knowing stance when assessing CNM relationships.

---

[4] The 2012 approval of Truvada for pre-exposure prophylaxis (PrEP), and improvements in access via financial subsidies, will hopefully continue to reduce the risk of HIV transmission via non-monogamous sex and other means; however, it does nothing to prevent other STIs such as syphilis and gonorrhea, both of which are on the rise again after years of historic lows.

[5] Blumstein and Schwartz's (1983) foundational study of American couples indicated that over a third of lesbian women said their relationship allowed for sex outside the couple, but this finding has not been replicated elsewhere.

[6] In part because most survey research continues to rely on binary categories of gender and fails to even document trans people's existence, let alone their experiences.

[7] Potentially at a rapid rate, as the internet facilitates closer communication among otherwise isolated individuals.

Romantic but Not Sexual Fidelity **Open Relationships.** The parameters of an open relationship can vary widely but are usually centered on a committed couple.[8] Typically, the couple develops an agreement that allows one or both members[9] to have extra-relational sexual partners.

> Reggie and his husband Malik tell their therapist that their open relationship has provided them with a healthy way to meet each man's needs. "Reggie likes variety," says Malik, "so he goes through periods where he does a lot of hooking up through the apps. I like to get to know folks a bit, so I have a couple of friends from the leather scene that I get together with a few times a year for an overnight or sometimes a weekend."

The specifics can vary greatly, from a kind of *don't ask, don't tell* arrangement in which each person has other sexual encounters without communicating or even acknowledging to one another that they are going on, to agreements that require all sex to take place with both members of the couple present, as a threesome or *moresome*. The amount of information shared, and the agreed-on characteristics of other encounters (gender(s), settings, activities) are specific to each couple, but a common assumption is usually that if outside partners become a threat to the dyad, the dyad will take precedence because of its special status. This may be upheld via the agreement that as a last resort, one partner can *veto* another's outside relationship(s).[10]

Swinging. This is a particular kind of open relationship which usually keeps non-monogamous sexual activity to swingers' parties or clubs, or encounters arranged in advance with other swingers (Taormino, 2008). While swingers may be friends with other couples,[11] the expectation is that sexual partners won't get attached emotionally. Swinging is almost exclusively heterosexual; however, we mention it in this chapter because in some scenes, women who are bisexual or *heteroflexible*[12] are particularly welcomed or seen as socially valuable. Some heterosexual women swingers we have worked with have reported feeling pressured into same-gender encounters; alternately, some have experienced pressure from male partners to pursue swinging because of their bisexuality. Although many swingers are quite happy with their arrangements, clinicians should be prepared to assess whether this is the case if a swinging couple presents for therapy.

Romantic and Sexual Plurality Many in this category identify with the term *polyamory*,[13] a neologism combining the Greek word for "many" and the Latin word for "loves," coined in the mid-20th century and in wide use by the 1990s (Jordan et al., 2016). Taormino (2008) uses the term to describe "the desire for or the practice of managing multiple significant, intimate

---

[8] Sex advice columnist Dan Savage (2011) coined the term "monogamish" to describe couples who are open to trying non-monogamous sex though not particularly actively pursuing or invested in it.

[9] While therapists may assume that all open relationships give the same leeway to both partners, this is not always true. Some open relationships develop as an adaptation to one member's much higher libido, or an attraction to more than one gender, or a desire for sexual activities in which their partner is not interested, in which case the other partner may have their own outside encounters or they may remain sexually as well as emotionally fidelitous. Clinicians need to be prepared to inquire specifically about the guidelines of a particular open relationship via the assessment process.

[10] There is much controversy in CNM communities about the ethics and meaning of veto power. It is most often a feature of open relationships and hierarchical polyamory; those who prefer other styles of relationship may criticize or look skeptically at those whose agreements include veto power.

[11] Individuals, particularly men, are often not permitted at swinging events.

[12] Primarily sexually interested in cisgender men, but open to sexual connection with partners of other genders at certain times or in particular circumstances.

[13] For decades, it has been common among polyamorists to use the abbreviation "poly" to refer to themselves and their communities. However, Polynesian activists have requested that, for clarity, those practicing non-monogamy use the entire term "polyamory" to clear up search term confusion and aid marginalized people in finding one another online (Patterson, 2018). Some non-monogamists have begun abbreviating "polyam" as a compromise.

relationships simultaneously"[14] (p. 72). Powell (2018) adds that polyamorous relationships must involve "the knowledge and consent of all involved" (p. 23).

Many polyamorists attest to the second-hand enjoyment they get via their partners' other relationships, an experience some call *compersion*. This experience is not exclusive to polyamory, but is often framed as an antidote to jealousy and as evidence that one has a more "evolved" perspective on relationships.[15] However, this emphasis on emotional maturity and connection sometimes expresses itself in a kind of back-handed contempt for swinging, open relationships, and other forms of casual sex (Klesse, 2006) that can feel distinctly sex-negative and work against a "peaceful coexistence based in mutual respect [for] people with different lifestyles" (p. 571).

Hierarchical Polyamory. These relationships typically include at least one dyadic, *primary* relationship in which "each partner in the primary couple can have one or more partners, but the additional partners are considered secondary, tertiary, or non-primary" (Taormino, 2008, p. 75). These designations are meant to structure the expectations of all involved about how resources and priorities are distributed.

The hierarchical model shares monogamy's assumption of an emotional and sexual home base, but can be expanded to include two or more primary partners, who may or may not themselves have other primaries, along with the option of secondary, tertiary, etc. relationships.

> Hao lives with their primary partner, Ocean, and Ocean's other primary, A.J. Hao has two secondary partners, Adrian, who is local, and Mads, who lives in the town where the two of them attended college. A.J. has several long-distance relationships with tertiary partners, while Ocean does not have other relationships right now.

Polyamorists, like those in open relationships, have great variety in the degree of contact or information among the different partners and *metamours*[16] in their *polycule*[17] (see Figure 17.1).

> Oliver is in a primary partnership with Ari, and has a lover Yuki. Ari is also dating Nahid. Nahid is also in partnerships with Jess and Toby. Oliver and Nahid are metamours (who have Ari in common). Yuki and Ari are metamours (who have Oliver in common). Ari, Jess, and Toby are metamours (who have Nahid in common). Oliver, Jess, and Toby consider themselves metamours, but jokingly refer to one another as "meta-metamours." Yuki has not met Nahid, Jess, or Toby, and does not consider them a part of her polycule. Nahid considers their polycule to include Oliver, Ari, Jess, and Toby. Oliver considers his polycule to include Ari, Yuki, Nahid, Jess, and Toby.

Labriola (2010) observes that although hierarchy may make multiple relationships seem easier to manage, feelings often refuse to be governed by agreements, particularly during periods of *new relationship energy* (NRE),[18] and can threaten to exceed a secondary relationship's capacity, creating challenges for all involved.

Polyfidelity. These relationships resemble traditional monogamy, but with three, four, or more members who agree to be exclusive with one another (Powell, 2018). Taormino (2008) points out that within this structure, there can still be a great deal of variation in terms of which

---

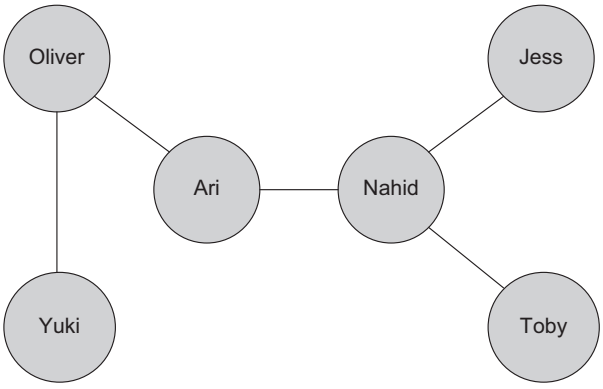
[14] Note that this definition can include those who have more than two intense and intimate relationships at once, even if they do not include sex; e.g., those who identify as asexual but still enjoy romantic connections.

[15] A framing highly contested by those who do not particularly experience compersion, naturally.

[16] The partner(s) of one's partner(s).

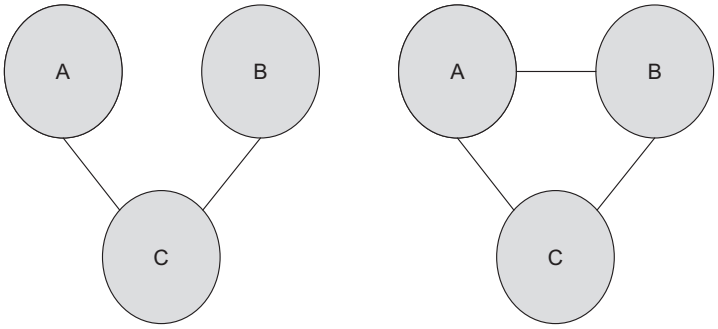
[17] The web of one's relational connections; also sometimes referred to as a romantic or sexual constellation.

[18] NRE, sometimes called *limerence*, is the period of passion, excitement, and/or infatuation that often occurs at the beginning of a new romantic or sexual connection. NRE can bring a very positive renewed energy and aliveness into a person's relationships, even those that don't involve the new connection, but can also feel threatening to existing relationships that are no longer in their initial NRE phase.



Oliver's metamours: Nahid, Jess, Toby
Nahid's metamours: Oliver, Yuki
Ari's metamours: Yuki, Jess, Toby
Yuki's metamours: Nahid, Ari, Jess, Toby
Jess's metamours: Oliver, Ari, Yuki, Toby
Toby's metamours: Oliver, Ari, Yuki, Jess

Figure 17.1 A polycule, showing direct relationships as solid lines



A "V" relationship

A triad relationship

Figure 17.2 Two types of non-monogamous relationships comprising three people, showing direct relationships as solid lines

dyads have sexual and romantic connections. For example, in a three-person "V" relationship, one of the dyads is not sexual/romantic, whereas in a *triad* or *throuple* all three dyads include this involvement (see Figure 17.2). A *quad* (four people) might be formed from two exclusively heterosexual couples in which the two men only have sex with the two women and vice versa, or some members might be bisexual/pansexual and have partners of more than one gender. An exclusively gay or lesbian foursome of only one gender might have some or all dyads sharing sexual and romantic intimacy (see Figure 17.3).

Kris, Sharon, Naomi, and Janet present for therapy as a polyfidelitous quad. Kris has sexual relationships with all three other women, as does Janet. Sharon and Naomi make up the original couple that the household began around, but in the past decade, they have decided to consider themselves family and "emotional spouses" but not romantic or sexual partners.

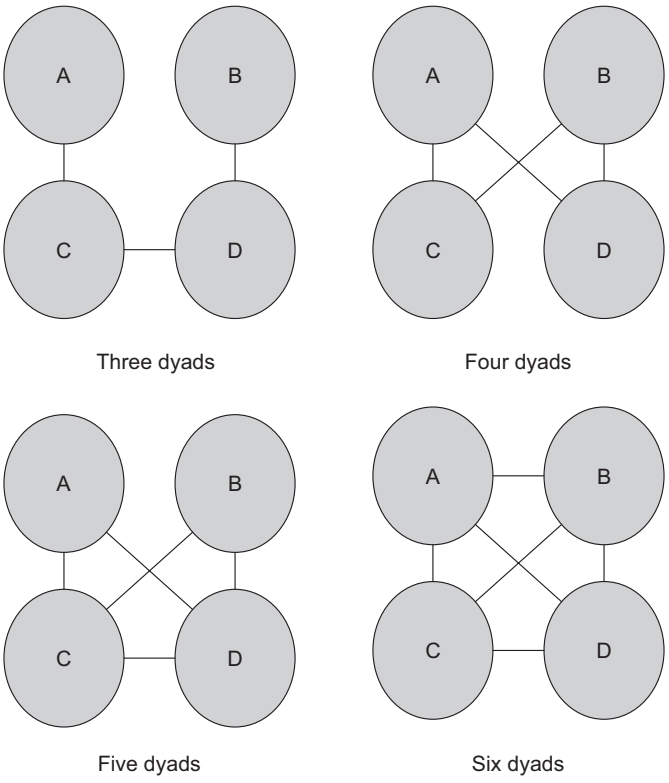


Figure 17.3 Four types of non-monogamous relationships comprising four people, showing direct relationships as solid lines

Non-Hierarchical Polyamory. Some feel that a structure that privileges one or more primary relationships limits how relationships can evolve and raises concerns over how these advantages are defined and enforced. Veaux and Rickert (2014)[19] point out that in hierarchical relationships, the members of the primary couple effectively have the power to set the rules and boundaries for all the non-primary partners as well. The inevitable power imbalance of a hierarchical structure may feel incompatible with some clients' values and ethics about intimate relationships.

Non-hierarchical polyamory sometimes offers more clarity about what it is not than what it is. It may share some characteristics with *solo polyamory*[20] as individuals negotiate their own ongoing, long- or short-term attachments to each of their "partners," "sweeties," or "lovers." Some polyfidelitous groups may identify as non-hierarchical, with each dyad (sexual or non-sexual) considered to be equally important. The core value is that "each relationship evolves independently of partners' other relationships…No one can veto a potential partner, or…insist on being the number one priority" (Labriola, 2010, p. 18).

Pincus and Hiles (2017) suggest that those who have seen or been part of a secondary relationship that ended painfully may hope a non-hierarchical approach will prevent another such outcome. A

[19] Since publication of Veaux and Rickert's 2014 book, many of Veaux's former partners, including Rickert, have come forward to describe similar patterns of emotional abuse and interpersonal manipulation (Leontiades, n.d.). Rickert has suggested that the book may have valuable tools, but acknowledges she was harmed by some of Veaux's ideas about jealousy and rules. She warns against relying on any single book, urging readers to "take what works for you from [multiple books]…If something doesn't feel right to you, listen to that feeling" (Rickert, 2019, para. 15).

[20] See later in this section.

non-hierarchical approach may allow enough fluidity to meet changing needs; or it may demand a degree of thinking, processing, negotiating, and problem-solving that some find unsustainable.

Relationship Anarchy (RA). RA is both a philosophy and a set of relational practices that seek to minimize the effects of power that are often structurally embedded in hierarchical models. The model's origins are explicitly political in nature (Nordgren, 2012), aimed at questioning and deconstructing relationship norms. Participants reject heteronormativity and monogamy as relational defaults and question the assumption that romantic and sexual relationships should have a higher status in one's life than platonic relationships (Nordgren, 2012).

RA welcomes *hybrid* relationships that do not fit neatly into usual categories. An RA adherent could have a platonic *nesting*[21] *partner*, a lover-friend, and two co-parenting partners, all of whom are different people. RA enthusiasts also welcome the possibility that relationships may change over time without needing to end and encourage direct negotiation among partners rather than relying on assumptions or cultural defaults. Clarifying one's values and principles in a relationship is key to "customizing your commitments" (Nordgren, 2012, para. 9). As such, it is well suited for those who prefer a high degree of autonomy[22] and spaciousness in their relational worlds.

However, relationship anarchy can be easily co-opted as a rationale for extreme and even harmful behaviors, such as refusing to make any relationship agreements, refusing to respect others' limits or emotional needs, or otherwise acting without regard for the impact on or harm to other people in the name of autonomy and self-determination. Clinically, it can be important to know how to assess for and address this phenomenon in individuals and couples that present for therapy, as the term *relationship anarchy* is sometimes a powerful and persuasive justification for mistreatment or even abuse.

Solo Polyamory. This style not only challenges monogamy, but the norm of partnering as well (Taormino, 2008). Pincus and Hiles (2017) point out that this may look a lot like monogamists' "just dating around" phase. For the solo polyamorous person, however, this is not a liminal period that will hopefully resolve into something better; this is what they prefer, perhaps for now due to life circumstances, perhaps long term due to personal preferences or needs.

> Dana is the single father of two boys whom he adopted with his ex-husband Trey. When Dana came out as transgender, Trey ended the marriage. Dana currently dates Angela, his long-time friend who lives next door with her wife Nenna and their daughter, and Baz, a friend from college who lives with their partner during the week but spends most weekends with Dana and his sons. Dana brings the boys to family therapy and wonders if Angela and/or Baz should be included, since they both help him parent. "The sex part of my relationships comes and goes depending on time and energy," Dana says, "but they've been pretty solid family for us the past few years."

Mono/Polyamorous. The mixed-preference relationship is of particular interest to many couple and relationship therapists because a common presentation in couple therapy involves one partner who wants to open the relationship to other partners while the other expresses reservations, disinterest, or outright refusal. It is common for therapists and clients to wonder whether such a relationship can ever work. A best-case scenario might involve deeply committed and well-resourced partners who are looking for options due to a difference in libido, sexual tastes, or introverted/extroverted styles (Taormino, 2008). A gridlocked, angry dyad in which each regards the other's preferences as morally and ethically objectionable faces a steep challenge (Powell, 2018).

---

[21] Nesting in this sense means to live together with the implication of mutual commitment and interdependence.

[22] Relationship anarchists explicitly do not believe in or practice veto power over one another's partners.

Maintaining a mixed relationship over the long term may involve times when both partners feel, sometimes acutely, that they are making an ongoing sacrifice—for the monogamous person, of their sense of security; for the non-monogamous person, of their sense of freedom (Veaux & Rickert, 2014). Support from the larger family and social system, which neither assumes the monogamous person is abused nor the non-monogamous person is controlled, can be critical (Taormino, 2008).

From our years of clinical and personal experience, we would argue that, like so many things in the realm of relationships and sex, there is no one correct or natural model of partnering that fits for everyone. Both monogamy and CNM come with inevitable tensions between autonomy and connectedness (Barker, 2018) that participants will have to figure out how to resolve. CNM is not a solution to most relationship problems,[23] or to cheating (Powell, 2018), or to compulsive sexual behaviors (Labriola, 2010). Instead, it is simply another set of relationship options that brings with it its own set of challenges.

Marriage, Couple, and Family Therapy Literature

Like queer and trans relationships in general, Marriage, Couple, and Family Therapy (MCFT) has been slow to acknowledge CNM relationships, and slower to consider how to address them clinically. The earliest journal articles in English appeared in the late 1970s, largely in publications focusing on sex research and social relationships (Rubin, 2001). Peabody (1982) published one of the first articles in the family sciences literature regarding CNM,[24] in which she urged therapists to consider the possibility that "swinging, open marriage…and group marriage" (p. 425), rather than a sign of pathology, might in fact be "supportive of the psychological health of the individuals" (p. 434). But her article appeared at the tail end of a brief surge of interest in "alternative lifestyles [sic]" during the 1960s and 1970s (Rubin, 2001); such scholarship then appeared to fall out of favor in the social sciences, perhaps because research dollars and interest shifted to two-income and blended families, perhaps due to the rise of HIV and the concomitant increase in stigma against multiple sexual partners. What little scholarship emerged during the rest of the 1980s seems to have centered mostly on swinging, although the subject of women's bisexuality was finally raised at this time (Dixon, 1984).

CNM enthusiasts were the first to bring their relationship advice into popular print in the form of *Loving More* magazine, published during 1984–2006 (*Loving More Magazine*, n.d.) Other non-monogamists, some with clinical backgrounds (e.g., Anapol, 1997; Easton & Liszt, 1997), some of them laypeople (e.g., Ravenscroft, 2004), self-published books or found homes at small alternative presses, a tradition which continues today for the most part (e.g., Gahran 2017; Mint, 2017; Minx, 2014; Patterson, 2018; Powell, 2018). Many of these reflect the preferences and norms of small urban liberal enclaves, and often feature a notably white, middle-class, heterosexual or bisexual perspective—the preferences and norms of a quite elite social group (Haritaworn et al., 2006).

The contemporary wave of peer-reviewed publications on CNM begins appearing around the mid-1990s (e.g., Kurdek & Schmitt, 1986; Shernoff, 1995) but family science and MCFT have continued to allow the sexuality journals to do the bulk of publishing on the topic, despite the fact that most popular writing focuses specifically on the relationship processes needed to navigate CNM relationships successfully, not on the sexual activities they permit and facilitate.

[23] "Relationship in trouble? Add more people!" is a joking way of framing this (usually failed) approach to CNM (Minx, 2014).

[24] Solely focused on heterosexual, cisgender relationships; although consistent with most authors at the time, Peabody did not acknowledge this.

Articles have tended to focus on heterosexual examples, with a small number addressing gay men (LaSala, 2001; Shernoff, 2006) and one on bisexuals (Weitzman, 2007).

Some of the most respected figures in relational therapy have expressed grave doubts or ambivalence about CNM. Johnson (2013), originator of Emotionally Focused Therapy for Couples (EFT/EFCT), has argued that humans are "naturally monogamous…wired to prefer mating and bonding with one partner for the long term" (p. 125). She cites the pair-bonding effects of oxytocin in the brain as evidence that "polyamory ultimately doesn't work so well" (p. 127), because, she argues, we will inevitably bond with those who juice our oxytocin output and want to forsake all others. Although she acknowledges that gay men in particular seem to have success with non-monogamy, in a 2014 interview, she theorized that

> being gay is changing, because our society is changing…As [same-gender] relationships are becoming legitimized, gay people are voicing the same kind of longings [for stability] as the heterosexual population…My perception is that in 20 years' time, I'm not sure if there's going to be much difference between the gay and heterosexual population.
>
> *(Bell, 2014)*

The official EFT training materials make no mention of CNM, and a relatively recent article on integrating EFT with sex therapy does not reference non-monogamy either (Johnson et al., 2018).[25]

John and Julie Gottman, developers of Gottman Method Couple Therapy, have not addressed CNM in any of their official publications or trainings. Their assessments, interventions, and overall model of relational health are clearly *mononormative*,[26] designed to be administered to a dyad presenting for therapy. In an online Q&A, Julie Gottman expressed doubts about CNM relationships' potential for lifelong endurance, suggesting that for many people, they may be solely about novelty seeking (Gottman & Gottman, 2019). However, The Gottman Institute (2019) offers definitions for polyamory and ethical non-monogamy on its "Love and Sexuality" blog and hosts at least two non-monogamous relationship stories under its "Real Relationships" series, suggesting willingness to acknowledge CNM relationships.

However, Perel appears to be affirming, perhaps even encouraging of CNM. She argues that intimate bonding and sexual chemistry are inherently at odds, proposing that "…love enjoys knowing everything about you; desire needs mystery. Love likes to shrink the distance that exists between me and you, while desire is energized by it. If intimacy grows through repetition and familiarity, eroticism is numbed by repetition" (Perel, 2006, p. 37). Perel's work largely focuses on how monogamous couples can incorporate this tension between longing and having into a more fulfilling sexual relationship. However, she has come to see monogamy as one of multiple "innovative" options in how to create relationships and families (2017, p. 260). And yet, she points out that CNM does not prevent boundary-crossing or betrayal: "If the desire to transgress is the driving force, opening the gate will not prevent adventurers from climbing the fence" (p. 257).

To date, the job of applying specific models of relational therapy to CNM relationships has been left to a single article. Kolmes and Witherspoon (2017) discuss the use of EFT and GMCT techniques to work with a mixed-gender couple, one of whom identifies as bisexual, one of whom as heteroflexible. The couple's crisis is spurred by unprotected sex between the cisgender

[25] There is little in the way of clinical or academic research on attachment as it relates to relationships including more than two individuals.

[26] Mononormativity: the assumption that healthy intimate partner relationships can or should only occur between two people who practice sexual and emotional fidelity with one another (Blumer et al., 2014).

wife and her cisgender male secondary partner. The field lacks any exploration of the application of well-documented, evidence-based relational therapy models to same-gender or trans-inclusive non-monogamous couples. Similarly, we could locate no evidence of literature that applies couple therapy models to triads, quads, or other types of polycules. Clearly, there is a significant gap waiting to be filled.

Presentations in Therapy

CNM offers a great deal of freedom for participants to determine their own relationship agreements. However, lack of successful, healthy CNM role models and the dearth of mainstream cultural (or even subcultural) narratives of happy CNM relationships can leave clients in CNM relationships unclear about what they want, what the options are, and what questions they should be asking themselves and one another.

In our clinical experience, CNM relationships often become the presenting issue in therapy[27] at four distinct points in a relationship's life cycle: (a) when one or both partners have proposed opening the relationship; (b) when something is not working between partners (e.g., someone feels jealous); (c) when something is not working somewhere in a larger CNM system (e.g., friction between metamours or triangulation); and (d) when there has been a trust breach of some kind. Issues regarding families with children—blending families, sharing information with children, and reproductive decisions—comprise the bulk of family therapy concerns; coming out to family of origin is another common theme. Here, we focus our attention on the first two points, as they are some of the most common presentations for CNM people in psychotherapy.

Opening Up

Couples who are opening up a relationship that has previously been understood to be monogamous[28] may come presenting symmetrically, with both parties interested in CNM, or asymmetrically, with one party ambivalent or even strongly against the idea. Clients may ask, directly or indirectly, for the clinician's opinion about whether they should try CNM or not. In order for clinicians to support symmetrical alliance-building with both parties, it is important[29] for clinicians to frame both monogamy and CNM as valid and legitimate relationship practices, but ones with different upsides as well as risks and drawbacks. Clinicians should neither encourage nor discourage clients' opening their relationship, but rather support the process of inquiry by fostering curiosity about their motivations, hopes, and fears about CNM (Kolmes & Witherspoon, 2017; Weitzman, 2007). Gottman Method Couple Therapy offers tools such as the "Rappaport Intervention" (a speaker-listener exercise designed to slow down reactivity and increase listening) and the "Dreams Within Conflict" conversation that can provide structure for these conversations while the therapist helps the couple cultivate an emotion focus that short-circuits the tendency to criticize, and respond to one another with validation rather than defensiveness.

CNM-affirming clinicians can support clients by offering guidance, expertise, and resources about CNM and how they might go about opening their relationship, then engage them in

[27] It is important to keep in mind that CNM clients also come into therapy for all kinds of reasons that have nothing to do with their relationships. Clinicians should not assume that because clients are practicing CNM, their relational practices are a problem (Grunt-Mejer & Łyś, 2019).

[28] Because the expectation of monogamy is dominant in North America and Anglophone countries, it is safe to say that any intimate relationship in which the partners have not directly and openly discussed whether or not to be monogamous is more likely than not a relationship in which at least one partner believes they are in a monogamous relationship. The dominance of the mononormative narrative tends to place monogamy as the default relationship structure, if not explicitly negotiated otherwise (although our clinical experience suggests this may be changing, particularly among younger populations and near urban centers).

[29] And ethical, in accordance with principles of client autonomy/self-determination.

ongoing self-assessment about how it is going. Shakti (2017) suggests that "it's a good idea to move as slowly as the person who is having the most difficulty adjusting…Otherwise, said person runs the risk of feeling rushed, backed into a corner, and/or like their feelings are no longer a priority" (para. 4). Therapists can help by validating the feelings of both clients, acting as a kind of anxiety sponge for the fears of the more reluctant partner and the urgency of the more eager partner.

Therapists helping couples through the process of opening their relationship will likely find themselves balancing the roles of psychoeducator and coach along with that of couple therapist. Shernoff (2006) notes that even as a CNM-affirming therapist, it can be important to "dispense cautions" (p. 415) about the potential challenges of non-monogamy, and to provide examples of topics the couple may want to discuss and/or make agreements on, such as sexual health and safety, information sharing, and even the definition of what constitutes "sexual behavior." In our clinical experience, assessing each partner's degree of interest and knowledge is essential in order to provide developmentally appropriate information, and avoid colluding with the more eager or well-informed partner.

> Jake sits on the edge of his seat nervously as his husband Kareem talks excitedly to the therapist. "So then I found the 'Poly Role Models Project' – do you know that one? And Kevin Patterson was speaking on his book the next week right across town from us, so I went to see him, and I loved what he had to say about white privilege in polyamory. I've been reading about this stuff for years, and listening to a lot of podcasts, and it's so clear to me that this is what I've been looking for." "What about you, Jake?" asks the therapist. "Are you keeping up with Kareem's research?" "Uh, not really," says Jake. "We've always fooled around on the side, but this whole 'many loves' thing is pretty new to me."

Clinicians may need to function as an expert interpreter between two relationship languages: the mononormative dominant discourse, which privileges sexual exclusivity and pair-bonding, and the CNM-friendly ecosystem, corners of which can be equally insistent about how "evolved" or "rational" non-monogamy is. Alternatively, the tension may be between one partner who is deeply invested in a view of polyamory or polyfidelity as respectable and safe but pathologizes "sleeping around" (Klesse, 2006), versus another who finds more liberal and casual sexual connections appealing and insists it is the only authentic way to do non-monogamy (Easton & Liszt, 1997; Powell, 2018).

Although no therapist can realistically be 100% up-to-date on a rapidly expanding and diversifying culture, the affirming therapist should recognize that a great deal of CNM discourse takes place online via blogs, Twitter, podcasts, and other new media. Self-anointed coaches, gurus, and other "experts" may come and go rapidly. This fluidity has created space for indigenous perspectives from the Black and indigenous people of color (BIPOC), queer, trans, disability, sex worker, and trauma-informed communities outside the ivory tower of academia and the regulated world of psychotherapy. The problem with such an open culture is that anyone can declare themselves an authority on CNM relationships, including those with problematic views or a history of abusive behavior. "If someone offers to teach you the 'right' way to do things and implies it happens to be the way they do things, be skeptical," cautions Powell (2018, p. 185).

Therapists should have sufficient skills in navigating online resources and communities to have some sense of current conversations around CNM, and to be able to locate and evaluate resources suggested by clients. Additionally, keeping up to date on recently released books on CNM can help affirming clinicians anticipate and recognize biases or troubling narratives that these resources might propagate. When new books are released and spread in popularity among CNM communities, often there are corresponding trends in clinical presentations as clients consume this literature and the newest perspective becomes a kind of subcultural belief system (Klesse, 2006). For example,

when Veaux and Rickert's (2014) book was published, many read it as saying that all hierarchical CNM models are controlling and fear-based. In our practices, this resulted in a trend of clients coming in feeling they needed to change their relationship agreements from hierarchical to non-hierarchical models because one or both partners felt shamed about their "unethical" or "controlling" relationship structure, not because the structure was not working for them.

Clinicians also have to be ready for very polarized clients to do some strenuous lobbying for either the monogamous or non-monogamous position. It is easy to become triangulated by the clients when there are strong feelings on both sides. Often, the partner advocating for non-monogamy will have chosen a therapist who identifies as CNM-affirming, assuming this means the clinician will be on their side; correspondingly, the partner more invested in monogamy may fear being pressured by the therapist as well as their partner. It is critical that the therapist assess power dynamics in the couple (Jordan et al., 2016), as well as in the clinical relationships, as client perception of the clinician's values regarding CNM can inform therapeutic alliance building. It is also important for clinicians to be explicit and self-aware about their competence working with CNM relationships, and be ready to discuss with clients any alliances that may be assumed due to their choice of clinician.

Assessment Tools Barker's self-assessment tools such as the "privacy-to-transparency" spectrum and the "separateness-to-togetherness" spectrum (2018) can aid in clarifying partners' preferences when opening a relationship. The privacy-to-transparency spectrum identifies how much each partner wants to know about one another's other relationships, as well as what kind of information they do and do not want to learn and the ideal timing of these disclosures. Whereas one couple may decide on a don't ask, don't tell agreement, in which little or nothing is shared about other partners, another might decide they want to know as much as possible as soon as possible about any new or potential connections their partner(s) might make. The separateness-to-togetherness spectrum refers to the degree of contact between metamours. Clients who need or prefer more separateness may never even want to meet their metamours, while those who desire more togetherness may design relationships with lots of connection between metamours, simultaneous time with multiple partners, and may approach CNM more like building a chosen family (this model is sometimes deemed *kitchen table polyamory*).

Relationship Agreements Relationship agreements help those in CNM relationships define clear areas of consent and expectations. They may cover areas like time together/apart, sexual health practices together and with others, type and timing of disclosures, and so on (Taormino, 2008; Veaux & Rickert, 2014; Weitzman, 2007). Relationships differ in terms of how many agreements they have and what kinds matter to them, as well as how stable or fluid they are over time. While monogamous relationships often assume shared understandings like "we don't have sex with other people,"[30] CNM practitioners must specify what their non-monogamy does and does not include.

When first opening a relationship, non-monogamous couples may find it helpful to make agreements that are time-limited, or that have "sunset clauses"—commitments to check in and revisit how the agreements are working at specific future dates.

> Jake and Moira come to therapy wondering if they can successfully open their relationship up to other sexual partners while still maintaining a strong marriage. "Since my transition, I'm finding that I have a lot of interest in sex with men that I never really noticed

[30] Note that what constitutes "having sex" can still be in question, often in retrospect. Such discrepancies are at the heart of many couple therapy sessions regarding "sexting," "cybersex," and "but it was just a kiss…"

before," Jake says. "Things are going well with us in the bedroom but Moira really misses sex with women and has a good friend she's been developing feelings for." With the help of their therapist, the couple agrees that they will try pursuing "no strings attached" sex with other partners for the next two months, while remaining in couple therapy to talk about how it feels for both of them. At that time, they agree that if either of them has strong negative feelings, they'll slow down and decide what to do next.

The following are examples of agreements which clients might make in the course of opening up or renegotiating the boundaries of a CNM agreement.

Examples of Relationship Agreements

- Oral and manual sex with others is ok with barriers, but anal sex is only for us.
- No sleepovers with other people.
- We will cohabitate but don't want any other partners to live with us or share finances.
- No dating our friends.
- Please tell me before you have a date with or have sex with someone else.
- I don't want to hear about crushes or dates, but please tell me as soon as possible when you have sex with a new person.
- We agree to use barriers with everyone outside of us.
- We only hook up with people together, never individually.
- We only connect with other people at events, and don't see anyone more than once or stay connected to them outside of events.
- I want to meet anyone you are dating regularly.
- I don't ever want to meet or hear about your other partners.

Examples of Geographic Agreements[31]

- When we go on business trips out of state, we can hook up with people but not when we are in town.
- The *100-mile rule*—we only have partners or lovers that live more than 100 miles from us.
- While we are in a long-distance relationship during this year-long job posting, we can casually date and sleep with other people with the agreement that once this year is over, we will focus on our relationship with one another for a while.

As partners work through the process of establishing agreements and testing their workability, it will likely be helpful for the clinician to help them articulate what each item is really for (Veaux & Rickert, 2014). For example, is an "only hook up when you're traveling" agreement important because one or both partners want to protect the privacy of their family life, or because they need to know they are a priority to their partner? Clarifying the underlying motivation behind agreements helps bring unspoken and unacknowledged beliefs, values, and longings into the conversation where they can increase understanding and trust in the relationship.

When Something Is Not Working

Jealousy

Some clients present to therapy because one or more partners are experiencing jealousy to a degree that causes individual distress and/or strain in the relationship. It is not uncommon for

[31] A particular type of relationship agreement that specifies that different sexual or romantic behavior is acceptable within or outside of certain geographic areas.

individual clients to seek help managing jealousy who have clearly come to believe that their jealousy is bad and wrong, that it is evidence of emotional immaturity or a lack of personal development. They may experience a great deal of emotional distress about their partner(s)' time spent with other partners, and then internalize self-judgment over their difficulty with acceptance and compersion. This can be a cause of or become intensified by interpersonal conflict between partners, and sometimes between metamours as well. Jealousy can also show up in the clinical space as a partner frequently asking to renegotiate relationship agreements to be ever more specific and restrictive as a way of trying to manage their relational and attachment anxiety, while their partner feels they can never quite succeed at behaving in a way that results in more trust.

Labriola (2013) offers two distinct models for approaching jealousy management in CNM relationships. The *engineering model* is an interpersonal and systemic approach to understanding jealousy. Within this model, one might ask what factors in the relationship or the larger system are contributing to the jealousy and what modifications in the relational system might be made to help lessen it (e.g., renegotiating agreements). However, the *phobia model* adopts a more individual approach. In this model, jealousy is an emotional phenomenon that can be managed through self-soothing, practicing distress tolerance, and exposure protocols. These two approaches are by no means mutually exclusive and in fact are complimentary.

Interventions for Managing Jealousy

Developmental Reframing It is normal that when people try something new or explore a new aspect of their identity, there is a period of confusion, exploration, acceptance, and eventual integration of this new practice or aspect of self. It can be helpful for clients new to CNM to hear that how they feel at the beginning of considering or trying CNM may not be how they feel forever, as more time and experience can bring clarity about their wants and needs, as well as build trust in themselves and their partners.

> Santiago and Greg began opening up their relationship two years ago. Initially, they agreed that they would not spend the night with outside partners in order to reinforce the idea that "I will always come home to you." Santiago wants to start having overnight stays with his secondary partner Miles, but Greg says he isn't comfortable with this development yet.

Normalization Jealousy is a normal human emotion, just as sadness, joy, frustration, or anger. CNM-affirming clinicians can challenge the belief that jealousy is either (1) evidence of a personal pathology; or (2) a problem that necessarily needs to be solved. Rather, it is an emotional experience. Like any other emotional experience, sometimes it is like "feelings weather" that ebbs and flows on its own over time; other times distressing feelings (including jealousy) are flags that point out unmet needs or boundaries. The clinical endeavor should include helping clients to tell the difference for themselves.

Am I Really a "No?" Clinicians can explore with clients, either individually or in conjoint therapy, how they determine when and if their jealous distress is a signal that they do not actually want to be practicing CNM, or do not feel comfortable with their current relationship agreements.

The "Intimacy Sandwich" Partners who struggle with jealousy-related distress can feel soothed by intentionally planning time together with their partner before and after their partner spends time with someone else romantically or sexually.

Accessing Support Systems Partners struggling with their experience of jealousy can benefit from accessing their existing support system for social and emotional support, and in particular can benefit from joining community or support groups specifically focused on CNM. Building platonic connections with CNM individuals and CNM community can serve to offer role models with more experience with non-monogamous relating who can offer their own wisdom about what did and did not work for them, and can potentially normalize jealousy.

Get Involved In general, having a wider variety of activities—a "full-plate life"—outside of the relationship in question can lead to greater self-esteem and resilience for folks struggling with jealousy and attachment anxiety related to CNM. Hobbies, activities, and community involvement essentially expand someone's world, which can offer a different perspective and potentially moderate the emotional impact of jealous distress in their romantic partnership(s).

Is Jealousy the Problem or the Symptom?

Just as in monogamous relationships, CNM relationships have their share of boundary violations. The "consensual" aspect of CNM is the basis of trustworthiness and thus secure attachment between relationship partners. Explicitly negotiating desires, boundaries, and risk tolerance can be a profound bonding experience between intimate partners, but it is not a prophylactic against jealousy and betrayal. While a mononormative concept like "cheating" or "infidelity" may not fit for CNM clients, when an agreement is broken, a boundary is crossed, or a falsehood is discovered, jealousy is just one of many emotions the hurt partner may experience as part of the trust violation.

A major failure of the CNM literature is the tendency to pathologize jealousy. At the extremes, this can result in authors suggesting that, for example, breaking an agreement—a serious attachment injury—can be a "signal that that one of your agreements needs to change; perhaps one partner wants an amendment to accommodate some new desire or person" (Taormino, 2008, p. 198). We would argue that the aftermath of a trust violation is perhaps the worst possible time to suggest broadening a relationship's boundaries or incorporating new partners. Therapy work in the aftermath of a CNM trust injury requires great commitment to meeting the hurt partner's needs for safety, just as it does in a monogamous relationship.

Equally frustrating for the systemic therapist are cases in which one partner clearly judges and looks askance at the other for their jealous feelings in the course of regular relationship challenges. While some CNM clients and communities have empathetic, vulnerable, and attuned adaptations for working through the anxious and uncomfortable aspects of non-monogamy (Ritchie & Barker, 2006), others avoid or resist relational conversations about jealousy with sophisticated reframes that locate the problem solely within the jealous individual(s), rather than within relationships (Leontiades, n.d.). This may involve framing jealous feelings as a one-person problem that should be resolved via individual, intrapsychic work on the self: identifying and challenging the reality of one's fears or beliefs, for example, or working to develop sufficient ego strength to shore up a fragile self-image and resolve jealous feelings without encroaching on others' activities.[32]

[32] While we acknowledge that both are potentially valuable interventions, we have rarely seen a reliance solely on the jealous partner's individual coping stabilize a relationship in crisis. In some cases, this is fertile ground for gaslighting and abuse to take place.

It can be particularly challenging when a dyad or relationship group presents with this view of jealousy and expects the therapist to teach the jealous person how to "deal with" (i.e., "get over/stop experiencing/extinguish") their jealous feelings—the "fix my/our partner" approach to couple therapy. In order to serve the relationship(s), the therapist has to resist aligning with this individualistic view. While supporting the value of developing self-regulation, coping, and skill-building, the therapist must offer a more relational, attachment-based reframe, while still attending to the therapeutic alliance with each member of the presenting unit. We find in our practices that a mixture of curiosity, validation, humor, and therapeutic challenge is necessary to disrupt this dynamic, and some clients who are particularly committed to seeing the jealous person as the sole problem can be very difficult to reach.

In our clinical experience, the one-person, intrapsychic view of jealousy frequently leads to a therapeutic dead end. Even in the event that jealousy is intensified by an individual issue such as anxiety, depression, or trauma, the underlying cause is likely to be an attachment protest which results in the clinging, seeking, angry, even attacking behaviors associated with an anxious-preoccupied adult, or the sullen, withdrawn, perhaps even numbed-out or punishing behaviors of the dismissive-avoidant adult (Johnson, 2008). The jealous client's desperate effort to get relief from the painful vulnerabilities stirred up by attachment injury is almost never effectively resolved via individual therapy or rigorous self-examination, as many CNM experts recommend. The most effective route to soothing attachment panic, relational therapists know, is the attuned, available presence of a partner who can turn toward the individual in crisis with and reach to connect with them in an empathetic fashion.

While CNM may represent ideals of "creativity, reflexivity, and freedom" (Heaphy et al., 2004, p. 169), this freedom does not necessarily accrue equally to all involved; it is inevitably influenced by attachment schemas, trust/bonding, and access to power. Sometimes jealousy is exacerbated by partners' differing access to potential outside partners due to stigmatized or de-valued aspects of their identity. Race, class, gender, gender presentation, sexual orientation, disability, body size, trauma history, age, and conventional standards of beauty can all impact an individual's social power, desirability, and access to partners. It is important to broach topics of power and privilege with CNM clients, particularly queer- and trans-including relationships, as these dynamics can be central to understanding and addressing underlying causes of jealousy that derive from social inequities rather than individuals or relationships.

Additional Clinical Issues in CNM

While CNM may be gaining mainstream exposure in recent years, many folks practicing CNM can feel adrift in "do-it-yourself" relationship models that, while potentially allowing for a lot of freedom, can also demand a lot of time and labor in order to do intentionally. CNM is still a stigmatized identity and practice. There are very few accessible cultural narratives, role models, or mainstream relational templates for CNM people, and those scant resources that do exist can be largely focused on white, middle-class, heterosexual CNM people and their families.

Metamours

Metamour relationships can pose particular challenges for CNM clients. Because that relationship is very specific to the CNM relational context, most people practicing CNM have little guidance or modeling about metamour relationships, how to navigate them, potential benefits, potential challenges, boundary concerns, or images of what healthy metamour relationships can look like. For clinicians, it can be helpful to provide clients with resources such as literature and community groups that might provide some guidance and cultural context for their interactions with metamours. Additionally, clinicians can serve a very important role in sharing experience, abstract clinical anecdotes, and outside resources (e.g., Turner, 2019; online blogs and podcasts

about CNM) that help committed CNM clients to have hope and construct their own narrative of healthy relating in their larger relationship system(s).

Secondary Relationships

Secondary partners in hierarchical non-monogamous relationships, and those who otherwise lack status and decision-making power due to their positionality with CNM relationships,[33] experience a variety of challenges related to their lack of status and decision-making power (Gahran, 2017; Jordan et al., 2016). While some may prefer to cultivate only relationships with a low degree of intimacy and/or commitment, it is not unusual for people to find themselves in secondary or extra-dyadic relationships when they would prefer one or more primary commitments (Labriola, 2010). It can be particularly difficult for everyone involved to feel a lack of sufficient closeness, security, resources, and/or leverage, and experience feelings of scarcity or powerlessness in their relationships.

Gahran (2017) proposes, as one possibility, a model of *non-escalator relationships* that are not built on the assumption that over time, the dyad will have increasing amounts of contact, interdependency, and commitment. By foregrounding the mononormative "escalator" sequence—dates increase in frequency, relationship descriptions become more formalized, lives become more intertwined, and a joint future is built over time—she invites those in CNM relationships to consider what it might look like to name, delineate, and honor relationships that are not meant (by virtue of design or available resources) to progress along this developmental path. She also highlights the way that (cis)sexism and cultural norms may make it easier to grant escalator status to those relationships that more closely resemble the heteronormative ideal than those that upend it via queerness, transness, and so on.

CNM in Families

Compulsory monogamy is a key part of the institutionalized, heteronormative vision of what a healthy family should be. Because of this, LGBTQ+ people who are practicing CNM and building families are multiply marginalized and face compounded risks of social stigma and discrimination. Literature on CNM families suggests that the primary reason that CNM parents do not disclose their non-monogamy to their children is related to custody issues or fear of potential custody issues (Sheff, 2011; Taormino, 2008). CNM parents can come to the practice of CNM after a monogamous relationship has ended, and so may be faced with the challenge of navigating co-parenting and custody arrangements with ex-partners (and their families) who are hostile to CNM. Stigma of CNM people as insatiable sex radicals with no boundaries, as well as misconceptions and assumptions about how CNM family life is structured, can genuinely endanger child custody and pull CNM parents into family court systems that reflect deeply entrenched monogamous, heteronormative ideals.

Legal marriage in the United States is built on heteronormative (and thus mononormative) foundations. This means that legal rights related to marriage have the assumption of monogamy embedded in the social institution. CNM people are limited by U.S. law that only allows one marriage at a time, and mandates that that marriage be between two people. CNM families are thus forced to form their own familial systems while beholden to the legal realities that only legal partners can have legal custody of children, rights to child support or alimony, merged finances for tax and inheritance purposes, rights related to medical decision making, and end of life issues for their partners.

[33] E.g., a bondage/discipline/dominance/submission/sadism/masochism (BDSM) *kink partner,* a *play partner/lover,* or a *friend with benefits* of someone in an open relationship

Sheff's research (2011) suggests that, similar to children raised in households with same-sex parents, children raised in polyamorous families tend to demonstrate no developmental impairments or differences when compared to their normative counterparts, and that the primary negative stressors for children in CNM families come from outside the family system. It seems that social and institutional stigma and discrimination are the highest risk factors for children in CNM families, not the practice nor structure of CNM itself.

CNM-affirming clinicians should be thoroughly informed about the real risks inherent in CNM people, particularly parents, coming out. Clinician open-mindedness and challenging the narrative that coming out as CNM is necessarily better or healthier is crucial, as idealized notions of coming out that fail to take into account structural and institutional risks of disclosure can endanger clients' and their families well-being, posing risks to custody as well as professional risks which can endanger family resources. For multiply marginalized folks who may regularly face discrimination related to race, class, gender, religion, immigration status, or disability, coming out as CNM can risk alienation from affiliative communities that provide much needed social support, resources, and contribute to resilience. It is important for clinicians to defer to client expertise as to the potential impacts to their family and community affiliations that coming out might pose, and to help them to assess and weigh the risks and benefits for themselves.

CNM and Social Justice

Positioned as it has been against mononormativity, and as part of the sexual liberation movement, CNM and its advocates have nonetheless been resistant to a social justice critique. Haritaworn et al. (2006) argue that "writers [about CNM] have neglected the violent racist, transphobic, ablist [sic] and [sizeist/lookist] context within which we all, as multiply positioned subjects, negotiate our sexual and partner choices" (p. 515). The authors point out that popular CNM literature's connection to the self-help genre means that, like self-help itself, authors "tend to endorse an abstract individualism at the expense of critiquing the structural power relations around race/ethnicity, gender, sexuality, and class" (p. 519). In other words, when the focus is on helping yourself, there is rarely an incentive to look at larger systems of oppression which one individual cannot change, or which they may in fact be complicit with.

Noël (2006) takes this point further, arguing that

> polyamory is typically theorized for and practiced by a certain group of readers. Indeed, the literature promotes the idea that polyamory can be an effective and revolutionary relationship choice for anyone, while simultaneously focusing on a particular type of person in American culture, namely an individual who is of 'European stock,' middle-class, college educated, and…probably also able-bodied.
>
> *(p. 606)*

While much of the literature on CNM purports to be adopting a universal, liberated viewpoint that is accessible to anyone and inclusive of "all human beings," many authors "eras[e] cultural context and realities while assuming greater cultural applicability than they can demonstrate or is in evidence" (p. 614).

Race

As with queerness and trans-ness, CNM is perceived as the domain of white people, despite the fact that people of color are well represented within its ranks (Levine et al., 2018). However, Patterson (2018) points out that the majority of popular books about CNM have been authored, at least in part, by white (cisgender) women, and comprehensively recounts the many ways white

polyamorists have failed to create welcome and safety for people of color (POC), from white-centric imagery to fetishizing and other-izing people of color. "If a group isn't being actively inclusive" of non-white people, he contends, "it's being passively exclusive" (p. 85). He also calls white polyamorists to task for using their inclusion of and relationships with people of color as token evidence of their diversity "cred," while erasing POC's actual voices and lived experiences. Although Patterson's experiences are largely in hetero- and cis-centric spaces, the issues he raises are still germane to LGBTQ+ CNM communities as well.

Haritaworn et al. (2006) argue that the reliance on narratives of freedom and self-actualization combines with negative stereotypes about the sexual behaviors and appetites of people of color (which are cast as inevitably threateningly large or pathologically anorectic) to center and then normalize white perspectives on CNM. At the same time, the "racialized new-age imagery" (p. 516) of polytheistic gods and goddesses, exotic pre-modern moralities, and a pre-Christian "natural" state of sexual freedom common to many books on CNM stems from an Orientalist view of the "primitive" as somehow more authentic and desirable, without acknowledging the racist and colonialist perspectives inherent in this framing.

Gender

Sheff (2006) looked at the gendered behaviors of the primarily heterosexual men in her largely white, well-educated, middle- and upper-middle-class community of polyamorists, and found that even these men, as invested as they were in striving for more egalitarian relationships with sexually empowered women, exhibited many traits of hegemonic masculinity, including relying on their female partners to manage the complexities of scheduling around multiple partners, using emotional distance to control their partners, and exhibiting a kind of emotional helplessness or incompetence in the face of relationship crises. They also tended to espouse conventional sexual ideals like having many female sexual partners, or having sex with two women at once, subsuming their bisexual partners' queerness into their own heterocentric sexual script.

Mint (2017) offers a gender-sensitive critique of the CNM dating world aimed at men (cis or trans) who date women (likewise). The double standards of physical appearance, courting and relationship behavior, power/control, and sexual boundaries all function to advantage men and disadvantage women[34] in CNM circles. Meanwhile, men's social and sexual attention functions as a kind of market currency that grants value to some women and not to others. Mint asks men to develop awareness of these taken-for-granted dynamics, and look for ways to "flip the script," give up or share power, and even expand their own politics of desire.

Class

Meeting, courting, and dating CNM partners are activities that, under capitalism, inevitably privilege those who have more financial resources. Shakti (2018) describes her compassionate frustration at watching her poor, disabled, trans partner try to cultivate new relationships while lacking the resources to even split the check for a lunch date. Although the internet has facilitated the establishment and maintenance of CNM relationships, even traveling across town or taking a motel room for a night to provide a modicum of privacy can be out of reach for poor and working-class people, never mind traveling to maintain a long-distance relationship. The cost of childcare, lack of a predictable work schedule or paid time off, and the need to provide care for disabled partners or parents can also present financial barriers to time with partners.

Even so, Noël (2006) argues that the challenge that CNM presents to compulsory heterosexuality, marriage, and child-rearing does fit with a more radical critique of inequality of all kinds. The same forces which support a conservative view of marriage and family also suggest

[34] And non-binary people.

pressuring the heterosexual poor into marriage, while shredding what little social safety net exists in the United States (and, for that matter, Canada). A queer and trans demand for access to marriage equality can align itself with these forces, or can act in coalition with the CNM communities and other "deviants" to advance the idea that heteronormative marriage should not be required in order to live a full and secure life, thereby addressing the "interests of a variety of people unduly affected by governmental policies around marriage and access to a fully realized citizenship" (p. 616).

Gender Identity, Body Size, Disability, and More

In today's dating environment, dating apps play an increasingly large role in finding partners. They can be particularly useful for those practicing CNM as many apps will allow users to screen for other people looking for non-monogamous relationships. For clinicians, it is important to be aware of the ways in which privileged and de-valued identities influence experiences of online dating that contribute to actual or perceived abundance or scarcity of sexual or romantic partners.

In heterosexually focused online dating environments, bisexual women are often highly desired.[35] This means that bisexual women using online dating are more likely to be frequently propositioned, to a degree that can feel overwhelming or objectifying if the propositions are mostly explicitly sexual. Conversely, transphobia is quite normalized and prevalent in many lesbian (Wandrei, 2018) and gay male online dating environments, which can pose particular dating difficulties and emotional hazards for transgender men who are looking to date other men. The social privileges and stigma of gender, race, body size/weight, dis/ability, etc. evident in mainstream dating culture are often amplified dramatically in online dating environments.

> Rock is a Black transgender man in a CNM relationship with Lucia, a Latinx bisexual nonbinary femme. Rock is seeking male partners through dating apps targeting cisgender gay men, but is encountering overt and subtle transphobia and racism from the men he meets online, which he is finding hard on his self-esteem. The scarcity of trans-affirming gay men on the apps he is using is discouraging and he feels compelled to go out with "any guy who will have me." Lucia is on several online dating apps targeted at both straight and queer people, and gets so many matches and messages that she feels overwhelmed and grossed out by the prevalence of explicitly sexual propositions from straight men and couples. Rock discloses in couples therapy that he is feeling jealous of the attention that Lucia gets on apps, and resents the ease with which she can find men who want to date or hookup with her. The imbalance between each of their experiences of online dating is causing increasing conflict in their relationship and they aren't sure what to do about it.

CNM is not a panacea for the inequalities of larger society. Although gay men and lesbians overwhelmingly express a desire for equality in their relationship(s), only half to two-thirds report actually achieving it (Peplau & Spalding, 2003). Differences in age, income, and investment in/dependence on the relationship all work against the egalitarian ideal, and, invariably, inform non-monogamy negotiations. And even in the era of marriage equality[36] the legal benefits of marriage, and the clarity they bring with them, are available only to dyads, leaving polyamorous partners struggling with ambiguity and unequal protection of the law (Green & Mitchell, 2015).

---

[35] At least in part due to stereotypes related to the sexual openness or availability of bisexual women, and the prevalence of heterosexual male, bisexual female couples practicing CNM.

[36] In the United States and Canada, in any case, though more countries and states are extending this fundamental human right of same-gender marriage every year.

Therapist Issues

CNM-Affirming Practice

Like LGBTQ+ clients generally, non-monogamous clients frequently have discouraging, stigmatizing, and offensive interactions with healthcare professionals (Henrich & Trawinski, 2016; Vaughan et al., 2019). They report a lack of appropriate assessments and screenings, use of judgmental or scolding language, and pressure to educate their providers who apparently lacked training on CNM. Although we lack research on whether this results in health disparities for non-monogamous people, we know this is one of the negative effects of a disconfirming healthcare environment for queer and trans people.

There are some easy, practical ways to create a more CNM-affirming practice. Intake forms can be revised to include plural language for relationships (e.g., asking about "partner(s)" or "spouse(s)") and offer a designated space for defining clients' relationship model or orientation.[37] If website or office art includes pictures of people, make sure to represent multi-partner relationships. During intake assessments, use phrasing that does not assume monogamy but leaves clients free to specify what kind of and how many relationships they are involved in.[38]

Clinicians sometimes find themselves working with Electronic Health Records or other established tools that are mononormative and may not be changeable. I (SA) am working to become a Certified Gottman Therapist, and as such, I administer the GMCT intake packet to every couple I work with, which I know asks clients to agree or disagree with statements like "I would refuse to have sex with a person other than my partner." I let clients know in advance that there are questions in the assessment that were written with the assumption of monogamy, ask them to answer as best they can or skip the question, and let them know that this will not interfere with or affect the feedback they get from me once I have looked over the assessments.

When working with CNM relationships, it is essential to keep an open mind about the unit of treatment, and perhaps even allow time for the appropriate unit to emerge via assessment. CNM clients who present as a couple, for example, may be embedded in a much larger relational system or polycule that contains other partners and metamours, some or all of whom may have a stake in the presenting problem. Although it can be valuable to work dyadically, as clinicians we have found that including other parts of the CNM system (such as additional partners or metamours) can create opportunities for powerful and lasting change.

It is important to organize office seating arrangements so there is space for three or more people. Having flexible or movable seating options can allow clients in multi-partner therapy to arrange themselves in the space as feels comfortable for them and can itself be a way of assessing relational dynamics such as coalitions, triangles, and closeness and distance. Seating arrangements such as a two-person loveseat plus a chair force non-monogamous clients to reckon with prioritizing one partner over another and can come off as thoughtless and exclusionary.

Self-of-Therapist Issues with CNM Clients

Clinicians interested in working with CNM clients should carefully reflect on their scope of competence (Fierman & Poulsen, 2014). While having an open mind about CNM relationships is a good start, this is different from having the clinical skills, gained through training and

[37] A blank space that clients can fill allows clients to self-define, but a multiple-choice format may be more accessible and easier to understand.

[38] Our clinical experience suggests that recently CNM discourse has split along two parallel narratives: those that discuss CNM as a relationship structure or practice, and those that discuss CNM as an orientation or more stable and enduring aspect of identity and psychological makeup.

experience, to actually provide effective and affirming services; having an affirming referral[39] ready for CNM clients may be the more respectful choice, given that this is a population that "might otherwise easily be scared away from therapy due to past exposure to institutional prejudice" (p. 156). Alternatively, seeking supervision or consultation from a more experienced therapist while also getting expert training (self-paced or otherwise) should be part of any clinician's plan when entering work with a new, specialized population.

The field of psychotherapy has a long-standing history of labeling those in non-monogamous relationships as having pathological defenses, personality disorders, sexual disorders, or other deficits in their ability to form healthy relationships, a prejudice which continues to show up in contemporary research (Grunt-Mejer & Łyś, 2019; Moors, 2019). Even as interest in and acceptance of CNM relationships has grown, monogamy is still the dominant model in both professional and popular literature on relationships. Clinicians should reflect critically on their own knowledge and stereotypes, as assumptions about the health or pathology of CNM can risk very real emotional harm to CNM clients seeking health care (Henrich & Trawinski, 2016).

It is vital for clinicians working with CNM relationships to maintain an open-minded and impartial stance toward the practice, particularly when working with couples where one partner is adamant about CNM and the other is critical of it. Effective clinicians for CNM clients should neither recommend non-monogamy nor discourage it and should be honest with clients about the potential risks and benefits of any relationship style. Important areas of reflection for clinicians and discussion in supervision or consultation include personal experiences of monogamy and non-monogamy, as well as other experiences in their family-of-origin and social circles. Sheff (2014) observes that people whose families or social circles have been touched by infidelity may find their pain, anxiety, and suspicion "enflamed by hearing about polyamory" (p. 127) to the point that they cannot maintain adequate professional detachment from the topic. At the same time, professionals who are positively disposed toward CNM must be cautious about becoming a kind of non-monogamy "cheerleader" and encouraging monogamously disposed clients to disregard their own preferences or boundaries.

Self-Disclosure and Multiple Relationships

Research shows that clients often feel more comfortable with participation and disclosure with therapists who share their identities or social affiliations, a phenomenon called self-matching (Gonyea et al., 2012). Clinicians working with LGBTQ+ clients practicing CNM may face choices about whether to self-disclose their own sexual orientation, gender identity, and relationship style/orientation in service of alliance-building with clients. In the case of a highly polarized couple, there may be no right answer to the question "are you non-monogamous?" as disclosure either way may raise concerns for one partner or the other.

CNM communities can be insular, particularly for those located outside of major metro areas. LGBTQ+ CNM communities are further circumscribed, which poses particular challenges for therapists who themselves identify as queer and/or trans and practice CNM themselves. Theory development about ethical best practices when client(s) and therapists are part of the same queer and/or trans communities is only in its early stages (Everett et al., 2013; Kessler & Waehler, 2005), and adding non-monogamy, with its potential for rapidly expanding networks of second- and third-hand connections, only creates more complexities. Queer and trans CNM therapists considering working with queer and trans CNM clients should carefully consider the potential personal impacts on one's dating life and community involvement of seeing clients from the same small subcultural communities that one belongs to and make a plan for managing potential risks and benefits, with consultation if possible.

[39] Such as from the Poly-Friendly Professionals list at https://www.polyfriendly.org/.

Conclusion

Consensually non-monogamous relationships may pose a challenge to couple and relationship therapists who are accustomed to monogamy as the preference and goal for all intimate partner relationships. However, because sexual and gender minority clients may be more likely to choose CNM relationship styles, clinicians working with these populations should be prepared to address CNM relationship needs in an affirming and effective fashion. Clinicians need to be prepared to meet these clients with forms, office space, vocabulary, and clinical practices that convey a non-biased viewpoint, up-to-date knowledge, and a willingness to stay open to ongoing learning, consultation, and self-of-therapist work regarding CNM cultures and practices.

In providing conjoint therapy to clients in CNM relationships, clinicians need to be prepared to distinguish when the presenting problems are potentially the result of non-monogamous dynamics that are not working or need further attention versus when they are problems that any intimate partnership might encounter, although still informed by the non-monogamous context. An affirming, non-pathologizing clinician can both hold the hope that troubled non-monogamous relationships can function better without giving up their CNM organization, and also acknowledge that CNM relationships are not right for everyone, nor always just or functional in how they operate. Offering a balance of affirmation and challenge, helping clients communicate with one another about needs and boundaries in an attuned and empathetic fashion, and connecting clients to adjunctive and supportive resources while respecting the values and autonomy of all clients are all essential parts of the conjoint therapy process with this population. By extending our view of what is possible to include happy, healthy non-monogamous relationships, we can help clients of all sexual and gender identities build their versions of the relationships they want to come home to.

References

Anapol, D. M. (1997). *Polyamory: The new love without limits: Secrets of sustainable intimate relationships*. IntiNet Resource Center.

Barker, M. -J. (2018). *Re-writing the rules: An anti self-help guide to love, sex and relationships* (2nd ed.). Routledge.

Bell, N. (2014, January 26). *Love Sense author says we're (mostly) like monogamous voles*. https://www.dailyxtra.com/love-sense-author-says-were-mostly-like-monogamous-voles-57601.

Bigner, J. J., & Wetchler, J. L. (Eds.). (2012). *Handbook of LGBT-affirmative couple and family therapy*. Routledge.

Blumer, M. L. C., Haym, C., Zimmerman, K., & Prouty, A. (2014, March/April). What's one got to do with it? Considering monogamous privilege. *Family Therapy Magazine, 13*(2), 28–33.

Blumstein, P., & Schwartz, P. (1983). *American couples: Money, work, sex*. Morrow.

Dixon, J. K. (1984). The commencement of bisexual activity in swinging married women over age thirty. *The Journal of Sex Research, 20*(1), 71–90. https://doi.org/10.1080/00224498409551207

Easton, D., & Liszt, C. A. (1997). *The ethical slut: A guide to infinite sexual possibilities*. Greenery Press.

Everett, B., MacFarlane, D. A., Reynolds, V. A., & Anderson, H. D. (2013). Not on our backs: Supporting counsellors in navigating the ethics of multiple relationships within queer, two spirit, and/or trans communities. *Canadian Journal of Counselling and Psychotherapy, 47*(1), 14–28.

Fairbrother, N., Hart, T. A., & Fairbrother, M. (2019). Open relationship prevalence, characteristics, and correlates in a nationally representative sample of Canadian adults. *The Journal of Sex Research, 56*(6), 695–704. https://doi.org/10.1080/00224499.2019.1580667

Fierman, D., & Poulsen S. (2014). Open relationships: A culturally and clinically sensitive approach. In T. Nelson & H. Winawer (Eds.), *Critical topics in family therapy. AFTA springer briefs in family therapy* (pp. 151–161). Springer.

Gahran, A. (2017). *Stepping off the relationship escalator: Uncommon love and life*. Off the Escalator Enterprises.

Gonyea, J. L. J., Wright, D. W., & Earl-Kulkosky, T. (2012). Navigating dual relationships in rural communities. *Journal of Marital and Family Therapy, 40*(1), 125–136. https://doi.org/10.1111/j.1752-0606.2012.00335.x

The Gottman Institute. (2019, June 10). *Gottman love and sexuality glossary.* https://www.gottman.com/blog/gottman-love-and-sexuality-glossary/

Gottman, J., & Gottman, J. (2019, February 14). *r/IAmA - We're John and Julie Gottman, relationship psychologists who studied over 3,000 couples in our lab. Ask us anything!* https://www.reddit.com/r/IAmA/comments/aqox9i/were_john_and_julie_gottman_relationship/

Green, R. J., & Mitchell, V. (2015). Gay, lesbian, and bisexual issues couples in therapy. In A. S. Gurman, J. L. Lebow, & D. K. Snyder (Eds.), *Clinical handbook of couple therapy* (5th ed., pp. 480–511). Guilford.

Grunt-Mejer, K., & Łyś, A. (2019). They must be sick: Consensual nonmonogamy through the eyes of psychotherapists. *Sexual and Relationship Therapy*. https://doi.org/10.1080/14681994.2019.1670787

Haritaworn, J., Lin, C. -J., & Klesse, C. (2006). Poly/logue: A critical introduction to polyamory. *Sexualities, 9*(5), 515–529. https://doi.org/10.1177/1363460706069963

Haupert, M. L., Gesselman, A. N., Moors, A. C., Fisher, H. E., & Garcia, J. R. (2016). Prevalence of experiences with consensual nonmonogamous relationships: Findings from two national samples of single Americans. *Journal of Sex & Marital Therapy, 43*(5), 424–440. https://doi.org/10.1080/0092623X.2016.1178675

Heaphy, B., Donovan, C., & Weeks, J. (2004). A different affair? Openness and nonmonogamy. In J. Duncombe, K. Harrison, G. Allan, & D. Marsden (Eds.), *The state of affairs: Explorations in infidelity and commitment* (pp. 167–186). Routledge.

Henrich, R., & Trawinski, C. (2016). Social and therapeutic challenges facing polyamorous clients. *Sexual and Relationship Therapy*. https://doi.org/10.1080/14681994.2016.1174331

Johnson, S. M. (2008). *Hold me tight: Seven conversations for a lifetime of love*. Little, Brown and Company.

Johnson, S. M. (2013). *Love sense: The revolutionary new science of romantic relationships*. Little, Brown and Company.

Johnson, S. M., Simakhodskaya, Z., & Moran, M. (2018). Addressing issues of sexuality in couples therapy: Emotionally Focused Therapy meets sex therapy. *Current Sexual Health Reports, 10*(2), 65–71. https://doi.org/10.1007/s11930-018-0146-5

Jordan, L. S., Grogan, C., Muruthi, B., & Bermúdez, J. M. (2016). Polyamory: Experiences of power from without, from within, and in between. *Journal of Couple & Relationship Therapy, 16*(1), 1–19. https://doi.org/10.1080/15332691.2016.1141135

Kassoff, E. (1989). Nonmonogamy in the lesbian community. *Women & Therapy, 8*(1–2), 167–182. doi: https://doi.org/10.1300/J015v08n01_14

Kessler, L. E., & Waehler, C. A. (2005). Addressing multiple relationships between clients and therapists in lesbian, gay, bisexual, and transgender communities. *Professional Psychology: Research and Practice, 36*(1), 66–72. https://doi.org/10.1037/0735-7028.36.1.66

Klesse, C. (2006). Polyamory and its 'others': Contesting the terms of non-monogamy. *Sexualities, 9*(5), 565–583. https://doi.org/10.1177/1363460706069986

Kolmes, K., & Witherspoon, R. G. (2017). Therapy with a consensually nonmonogamous couple. *Journal of Clinical Psychology, 73*(8), 954–964. https://doi.org/10.1002/jclp.22509

Kurdek, L. A., & Schmitt, J. P. (1986). Relationship quality of gay men in closed or open relationships. *Journal of Homosexuality, 12*(2), 85–99. https://doi.org/10.1300/J082v12n02_06

Labriola, K. (2010). *Love in abundance: A counselor's guide to open relationships*. Greenery Press.

Labriola, K. (2013). *The jealousy workbook: Exercises and insights for managing open relationships*. Greenery Press.

LaSala, M. C. (2001). Monogamous or not: Understanding and counseling gay male couples. *Families in Society: The Journal of Contemporary Social Services, 82*(6), 605–611. https://doi.org/10.1606/1044-3894.155

Leontiades, L. (n.d.). *Polyamory's #MeToo.* https://polyamory-metoo.com/

Levine, E. C., Herbenick, D., Martinez, O., Fu, T. -C., & Dodge, B. (2018). Open relationships, nonconsensual nonmonogamy, and monogamy among U.S. adults: Findings from the 2012 National Survey of Sexual Health and Behavior. *Archives of Sexual Behavior, 47*(5), 1439–1450. https://doi.org/10.1007/s10508-018-1178-7

Loving More Magazine. (n.d.). https://www.lovingmorenonprofit.org/magazine/.

Malpas, J. (2006). From otherness to alliance: Transgender couples in therapy. *Journal of GLBT Family Studies, 2*(3/4), 183–206. https://doi.org/10.1300/J461v02n03_10

Malpas, J. (2012). Can couples change gender? Couple therapy with transgender people and their partners. In J. J. Bigner & J. L. Wetchler (Eds.), *Handbook of LGBT-affirmative couple and family therapy* (pp. 69–85). Routledge.

McLean, K. (2004). Negotiating (non)monogamy. *Journal of Bisexuality, 4*(1–2), 83–97. https://doi.org/10.1300/J159v04n01_07

Mint, P. (2017). *Playing fair: A guide to nonmonogamy for men into women*. Thorntree Press.
Minx, C. (2014). *Eight things I wish I'd known about polyamory before I tried it and frakked it up*. Do the Work.
Moors, A. C. (2016). Has the American public's interest in information related to relationships beyond "The Couple" increased over time? *The Journal of Sex Research, 54*(6), 677–684. https://doi.org/10.1080/00224499.2016.1178208
Moors, A. C. (2019). Moving past the rose-tinted lens of monogamy: Onward with critical self-examination and (sexually) healthy science. *Archives of Sexual Behavior, 48*(1), 57–61. https://doi.org/10.1007/s10508-018-1215-6
Noël, M. J. (2006). Progressive polyamory: Considering issues of diversity. *Sexualities, 9*(5), 602–620. https://doi.org/10.1177/1363460706070003
Nordgren, A. (Jul 06, 2012). *The short instructional manifesto for relationship anarchy.* https://log.andie.se/post/26652940513/the-short-instructional-manifesto-for-relationship
Patterson, K. A. (2018). *Love's not color blind: Race and representation in polyamorous and other alternative communities*. Thorntree Press.
Peabody, S. A. (1982). Alternative life styles to monogamous marriage: Variants of normal behavior in psychotherapy clients. *Family Relations, 31*(3), 425–434. https://doi.org/10.2307/584176
Peplau, L. A., & Spalding, L. R. (2003). The close relationships of lesbians, gay men, and bisexuals. In L. D. Garnets & D. C. Kimmel (Eds.), *Psychological perspectives on lesbian, gay, and bisexual experiences* (2nd ed., pp. 449–474). Columbia University Press.
Perel, E. (2006). *Mating in captivity: Unlocking erotic intelligence*. HarperCollins.
Perel, E. (2017). *State of affairs: Rethinking infidelity*. HarperCollins.
Pincus, T., & Hiles, R. (2017). *It's called "polyamory": Coming out about your nonmonogamous relationships.* Thorntree Press.
Powell, D. L. (2018). *Building open relationships: Your hands-on guide to swinging, polyamory, and beyond!* Dr. Liz Powell LLC.
Ravenscroft, A. (2004). *Polyamory: Roadmaps for the clueless and hopeful*. Fenris Brothers.
Rickert, E. (2019, September 6). *Thoughts on the fifth anniversary of more than two.* https://brighterthansunflowers.com/2019/09/02/thoughts-on-the-fifth-anniversary-of-more-than-two/
Ritchie, A., & Barker, M. (2006). 'There aren't words for what we do or how we feel so we have to make them up': Constructing polyamorous languages in a culture of compulsory monogamy. *Sexualities, 9*(5), 584–601. https://doi.org/10.1177/1363460706069987
Rubin, R. H. (2001). Alternative lifestyles revisited, or whatever happened to swingers, group marriages, and communes? *Journal of Family Issues, 22*(6), 711–726. https://doi.org/10.1177/019251301022006003
Savage, D. (2011, July 20). *Monogamish*. Savage Love. https://www.thestranger.com/seattle/SavageLove?oid=9125045
Shakti, A. (2017, September 20). *I fell in love with someone whose partner isn't polyamorous. Help!* https://www.iampoly.net/blog/2017/9/20/help-i-fell-in-love-with-someone-whose-partner-isnt-cut-out-for-polyamory
Shakti, A. (2018, January 25). *How do I navigate mixed class relationships in non-monogamy?* https://www.iampoly.net/blog/2018/1/24/how-do-i-navigate-mixed-class-relationships-within-a-non-monogamous-framework
Sheff, E. (2006). Poly-hegemonic masculinities. *Sexualities, 9*(5), 621–642. https://doi.org/10.1177/1363460706070004
Sheff, E. (2011). Polyamorous families, same-sex marriage, and the slippery slope. *Journal of Contemporary Ethnography, 40*(5), 487–520. https://doi.org/10.1177/0891241611413578
Sheff, E. (2014). *The polyamorists next door: Inside multiple-partner relationships and families*. Rowman & Littlefield.
Sheff, E. (2018, December 2). *Against compulsory (non)monogamy.* https://www.psychologytoday.com/us/blog/the-polyamorists-next-door/201812/against-compulsory-nonmonogamy
Shernoff, M. (1995). Male couples and their relationship styles. *Journal of Gay & Lesbian Social Services, 2*(2), 43–58. https://doi.org/10.1300/J041v02n02_03
Shernoff, M. (2006). Negotiated nonmonogamy and male couples. *Family Process, 45*(4), 407–418. https://doi.org/10.1111/j.1545-5300.2006.00179.x
Taormino, T. (2008). *Opening up: A guide to creating and sustaining open relationships.* Cleis Press.
Tunnell, G. (2012). Gay male couple therapy: An attachment-based model. In J. J. Bigner & J. L. Wetchler (Eds.), *Handbook of LGBT-affirmative couple and family therapy* (pp. 25–42). Routledge.

Turner, P. (2019). *Dealing with difficult metamours*. Braided Studios, LLC.
Vaughan, M. D., Jones, P., Taylor, B. A., & Roush, J. (2019). Healthcare experiences and needs of consensually non-monogamous people: Results from a focus group study. *The Journal of Sexual Medicine, 16*(1), 42–51. https://doi.org/10.1016/j.jsxm.2018.11.006
Veaux, F., & Rickert, E. (2014). *More than two: A practical guide to ethical polyamory*. Thorntree Press.
Wandrei, K. E. (2018). 'Sleeping with the enemy': Non-monogamy and 1970s lesbian-feminists. *Sexualities, 22*(4), 489–506. https://doi.org/10.1177/1363460717750074
Weitzman, G. (2007). Counseling bisexuals in polyamorous relationships. In B. A. Firestein (Ed.), *Becoming visible: Counseling bisexuals across the lifespan* (pp. 312–335). Columbia University Press.

Taylor & Francis
Taylor & Francis Group
http://taylorandfrancis.com

Section IV
Special Issues

Taylor & Francis
Taylor & Francis Group
http://taylorandfrancis.com

18
"I Didn't Know I Had a Right to Exist"
Queer Elders and Family Therapy

PAUL D. LEVATINO

Introduction

In many ways the emergence of LGBTQ recognition has moved at rapid speed. Ideas that would have caused uproar ten years ago (such as the national legalization of same-sex marriage or the mainstream presidential candidacy of an openly gay man) are routine and taken for granted in many circles. In the United States, the legislative repeal of *Don't Ask, Don't Tell* in 2010, the Supreme Court ruling legalizing the right for same-sex couples to marry in 2015, and the most recent 2020 Supreme Court ruling banning discrimination bias based on sexual orientation and gender identity in employment signaled forward progress. Yet the evolution of civil rights and the societal treatment of the queer[1] community remains uneven: transgender individuals were afforded the right to serve in the military in 2016 under the Obama administration only to have this right taken away during the Trump administration. Transgender individuals, granted healthcare protections under the Obama-era Affordable Care Act in March 2010, had those protections revoked in June 2020. This uneven progress is noted on the world stage where in the year 2019, 70 United Nations recognized member states criminalize same-sex sexual activity (Avery, 2019). In the interim, white nationalists marched in Charlottesville, Virginia in 2017 shouting racist, anti-Semitic, and anti-queer chants. According to the National Coalition of Anti-Violence Programs, January through August of 2017 saw the largest number of recorded queer hate-crime homicides in the United States, with 36 deaths reported within the eight-month period (Waters & Yaka-Bible, 2017). Seventy-five percent of those murdered were queer people of color. Meanwhile, 16 transgender women of color (comprising a staggering 44% of the total) were slaughtered based on society's prevailing cisgender and white-centric orientation. The struggle for equality among the queer community is steady and forward for some, while steadily stagnant for others.

The larger struggle in any social justice movement cannot be encapsulated in any one single, homogenous person or social identity (Olzak & Ryo, 2007). Within movements are individuals made up of unique permutations of identity, each struggling for justice and self-worth which is exacerbated or alleviated by their particular, cumulative experience of oppression. For example, the struggle for equity and non-biased treatment among queer people includes LGBTQ people of differing ages, various racial, ethnic, and cultural backgrounds, people of diverse socio-economic strata, people of different gender identities, sexual orientations, religious orientations,

[1] Throughout this work I use the potentially controversial word "queer" in an effort to provide a broad base of inclusivity of what is now commonly referred to as LGBTQI+. The purpose of this is two-fold: the first is for the sake and simplicity in reading and writing, and the second is to acknowledge and encourage cognizance that the discourse and understanding related to gender identity and sexual orientation are emerging and ongoing

DOI: 10.4324/9780429274626-23

multi-national, and/or multi-racial identities, among other characteristics. Work by Harvey et al. (2020) and Sultana (2012) explores how patriarchal influences organize and stratify individuals and identity qualities into a hierarchy of more or less empowered positions. Within the queer community, certain subsets of the population are afforded more or less recognition and value based upon the degree to which they align with characteristics of the prevalent, empowered cultural paradigm. For example, a financially affluent, young, straight acting, white, abled, cisgender gay-identifying male is afforded more opportunities (and less likely to experience discrimination) than a transgender, differently abled woman of color. This is because the former aligns more closely to what is valued and therefore privileged in the prevailing empowered cultural paradigm, whereas the latter diverges from and is seen to threaten that empowered prevailing paradigm. Queer elders are perceived and treated as though they have less value than younger, more abled counterparts (Jones, 2001). They face discrimination, social isolation, and declining faculties and resources. At a vulnerable age they are also asked, overtly and/or covertly, to "un-queer" themselves and surrender, suppress, and deny their queer identity in order to fit into heteronormative, white-centric expectations and settings. Queer elders explain this experience first-hand in the documentary film *Gen Silent* (Maddux, 2010). Like other oppressed populations, they are asked to do this because their identity is met with resistance and condemnation by the dominant white, cisgender, patriarchal, heterosexual informed and oriented majority. This is an example of the vulnerable minority being asked (and/or told) to take care of those in positions of power and privilege to the detriment of their own identity, worth, and self-esteem. In the United States, instances of this include the *Defense of Marriage Act* (United States, 1996) that denied public recognition and ability for same-sex couples to marry, and the Department of Defense (1993) directive *Don't Ask, Don't Tell*, which prohibited queer service members from serving in the armed forces should they disclose homosexual orientation or speak about their homosexual relationships.

Intersectionality and the Queer Community

Intersectionality allows for the examination of simultaneous and interwoven identity attributes that when considered cumulatively and simultaneously (versus singularly and separately) assist in understanding the impact of systems of power and privilege on disempowered and disenfranchised populations. Crenshaw (1989) initially developed and applied the concept of intersectionality to highlight "the multidimensionality of Black women's experience with the single-axis analysis that distorts these experiences" (p. 139).

Intersectionality is a multi-faceted way of looking at experiences that, like systems theory, integrates and holds larger complexities. Rather than considering individual or binary perspectives, intersectionality integrates dualistic summations and considerations to conceptualize systemic social relations and interactions through a more holistic lens. An intersectional examination of systems of power and privilege reveals that those closest to dominant identities are afforded more comfort, privilege, and power without expending additional work or effort. Those with identity attributes further from individuals in power receive increased levels of discrimination, prejudice, and threat to physical and mental harm, and, as a result, fewer opportunities for advancement. This occurs without any action or offense done on their part. This systemic discrimination, bias, and oppression is documented in multiple works (Gaddis, 2015; Kang et al., 2016; Kattari et al., 2016; Oreopoulos, 2011; Zhao & Biernat, 2017).

By viewing these summative identity qualities and the relationship of these qualities vis-à-vis the prevailing empowered cultural paradigm, a systemic psychotherapist is better able to conceptualize the additional burdens or benefits experienced by individuals within a systemic whole. Crenshaw explains that privilege is granted to those who happen to occupy the most desired identity characteristics and from that position all else is organized and judged, "this focus on the most privileged group members marginalizes those who are multiply-burdened" (p. 140). One of the

benefits (and burdens) of intersectionality is that it adds complexity and nuance which McCall describes as "the complexity that arises when the subject of analysis expands to include multiple dimensions of social life and categories of analysis" (2009, p. 1772). Subsequent authors have integrated the principle of intersectionality when discussing the impact of societal oppression on the queer community (Adames et al., 2018; Addison & Coolhart, 2015; Kuper et al., 2018).

Challenges of Queer Elders

Queer elders are often outliers within groups that, at first glance, they seem to share much in common with. As a group they share some physical, emotional, and relational requirements with similarly aged, non-queer elders, yet have unique needs distinct from this population. The following case vignette, combining details from cases to provide anonymity, provides an example.

Martin (age 74) and Devon (age 70) are an interracial couple together for over 27 years. They were married 12 years ago in 2008 when the State of Connecticut's Supreme Court decision allowed them to do so. Shortly after their marriage they both agreed to enter a residential retirement community to "relax and enjoy time twilight years with people like us." Following move-in, problems began to surface when during the first months they discovered they were surrounded by people of their age, but with markedly different, non-queer, white-centric life experiences. Martin (identifies as Black/Caribbean-American) in particular is challenged by the transition into the living environment, grieving the loss of previous friends and living circumstances while adjusting to an almost exclusively heterosexual, white community. While Devon (identifies as white/Latino mix) acknowledges the challenges of the transition, he finds the transition less jarring and more manageable. The stress in their individual experiences brings them into escalating conflict with one another and as a result into couples' counseling. Here I attempt to help Martin and Devon realize that while they were clearly experiencing conflict with one another, perhaps what had changed was not something in their relationship, but rather external social circumstances and pressures.

Devon: Moping around the house does not make Maple Ponds any better. It makes me and you miserable and I don't know what's changed in you but you have to stop.

Martin: It does not make it more of anything and you don't acknowledge a goddamn bit how we moved into a white, uppity, straight, shithole. I have nothing in common with these people. They were drinking Peppermintinis, Devon! Would we have ever had a Peppermintini with Isaac and Jessie? Would we give a shit about a Peppermint martini?!?

Devon: Well, Jessie is dead and Isaac had a stroke, so I say no, you're right. We probably won't be having Peppermintinis with them. I think you have to decide if you want to be miserable, because if you do, I will not be like you!

Therapist: Maybe this is not as much about the two of you being different from one another. I wonder if your living circumstances changed. You went from one community, aware and able to connect to one another and those relationships through the lens of part of who you are—Black, Latino, and queer—and into this community, mostly all white and straight? Maybe they [this community] cannot give you what others [in your past] gave you. Maybe this is about this current community letting you down and not about you letting one another down?

Martin: Well…if that is true what are we supposed to do with that?

Therapist: What could you do with it, if this current community cannot show up for you?

Martin: Maybe show up for each other?

Couples work helped Devon and Martin realize that little had changed in their relationship with one another since arriving at Maple Ponds. What changed was their connection to queer

friends and people who shared similar identity, which was less accessible and unrepresented within Maple Ponds. Even though surrounded by fellow septuagenarians, feelings of isolation, disconnection, and frustration caused by social disconnection seeped from social relationships into their couple relationship. They shared similar age with residents of Maple Ponds; however, Maple Ponds could not connect to or acknowledge parts of Martin and Devon's unique intersection of age, race, and queer identity.

While queer elders share some attributes with non-elder queer individuals, they have needs distinct from younger queer counterparts as well. The intersectionality of ageism and queer identity reveals that queer elders, and particularly non-white minoritized elders, are often excluded from majority queer communities. An example of this was explored at a retreat center whose primary clientele is middle-to-elder age gay and bisexual men. In this vignette, minoritized participants reported feeling marginalized based on expectations that emerged around race, age, and ableism during a closing circle.

José (age 81) and Matt (age 80) were attending a retreat marketed to gay men. Octogenarians, they were able-bodied, spry, and active for their age. The particular retreat happened to be attended by a majority of people in their early- to mid-50s. At one point they expressed how, despite feeling welcome and accepted for part of who their identity [gay men], thought other parts of their identity were unknowingly disparaged during the retreat:

José: I think we talked a lot about brotherhood and I acknowledge that I identified as a gay male my entire life. Now I am 81 and had treatment for prostate cancer. Lupron treatment tanked my testosterone and I realize just how much of male sexuality, when it was discussed this weekend, was youth-based and oriented around masculine stereotypes. I don't see myself as just a gay man anymore. I see myself more connected to my feminine side as ever. I don't know if that side was affirmed here.

Matt: During the tantric massage workshop, it was assumed that getting an erection was going to happen and that the penis was a focal point of male sexuality. And I think we fell victim to that idea before José's cancer as well. People inference José's Latin virility and I am realizing it leaves us in a box; we are Latin and queer so we have to be youthful and virile and gay MEN, or somehow we are less than if we are not. Sorry folks, we are tired of being your porn fantasy stand-ins. In my twenties I was probably guilty of that game. Now, my penis is part of who I am, it isn't ALL of who I am. And my husband painting his nails shocked me at first, and now I realize how it liberated us.

José and Matt's experience demonstrates that despite sharing similarities with fellow retreat attendees, other parts of their identity were unacknowledged and felt unwelcome in the majority created retreat experience. They were gay men, AND octogenarians, Latino, and a couple in which one partner was a recent prostate cancer survivor who experienced his sexual activity, gender expression, and identity transition in the process. Acknowledgment of the emergence of José's emerging comfort with more feminine aspects of sexuality and the couple's experience with Latino stereotypes cast onto them (and self-introjected by them) were only recently claimed by them, and lost among the expression and acknowledgment of majority. The intersectionality of these attributes contributed to feelings of separation and disconnect from the other retreat attendees despite the fact that every attendee shared the same biological anatomy and attraction to other "men." Matt and José's experience reminds us that it is common for the majority within a group to define and impose its identity and expectation onto the broad community, devaluing minority identity and experiences. There is no single queer community, and the affirmative systemic therapist remains cognizant not to impose the queer community they reside in and/or identifies with most easily onto clients. As a vulnerable population, queer elders are especially at risk when this reflection and inventory does not occur.

The emotional impact of the interactions between younger and elder gay community members is well documented. Work by Grossman (1997) and Weeks (1981) details the rejection of gay male queer elders by younger community members and subsequent self-imposed isolation by the elder. Schope (2005) found that compared to lesbians, gay men have more negative views about growing old and report more fear of being negatively evaluated by others as they age. In Israel, research by Shenkman et al. (2018, 2020) established that gay male elders report more depression and anxiety and lower levels of happiness than similar-aged heterosexual identifying peers. Examples of the impact and permutations of queer elders not experiencing a queer supportive environment are included in the case vignette later in this chapter involving Amanda and Jasmine.

In the United States, only a few metropolitan centers have senior housing facilities dedicated to serving queer populations; these include recently developed facilities in New York and Los Angeles (Branson-Potts, 2014; Hu, 2017). SAGE (https://www.sageusa.org/) is a national organization with local affiliates providing advocacy and resources for queer elders, including oversight of five queer elder housing centers in New York City. While some senior communities are embarking on cultural competency training that addresses the needs, treatment, and acknowledgment of queer elders, many have not. The remainder of queer elders reside within heterocentric-oriented communities where their queer identity is frequently ignored and/or unacknowledged, rendering their identity neutered and critical aspects of their personhood invisible. In the case example, Jasmine and Amanda are a queer couple in their 70s experiencing social isolation and disregard of their queer relationship by fellow residents and staff at their newly chosen independent living elder care facility. Jasmine and Amanda's situation is not unique. Knauer writes, "Based on the limited research available and considerable anecdotal evidence, the lives of many LGBT elders are solitary and closeted, plagued by fear of disclosure and financial insecurity" (2009, p. 3). She cites challenges of aging in isolation from family, separation from queer community, and invisibility in mainstream considerations of aging particularly challenging to queer elders. Knauer found that queer elders often remain silent about their identity to their healthcare providers and feel uncomfortable owning and sharing their identity in institutional settings such as long-term care, assisted living facilities, and skilled nursing communities. She states this is emblematic of a culture that orients itself toward a married, heterosexual, and with-progeny standard, "existing aging policies assume an individual has a multi-generational family of origin ready and able to provide support" (2009, p. 6). Brown (2009) echoes Knauer's belief about the silencing of queer elders from communities of potential inclusion, "the exclusion of LGBT elders from queer theory and gerontological theory has resulted in the silencing of LGBT elders and their lived experiences" (p. 66). In the United States, queer elders in their youth and adulthood often experienced risk of institutionalization at the hands of the medical and psychiatric professions. As a result, they are often reluctant to identify as queer in unknown situations, reluctant to seek out advocacy, and/or tentative to seek medical or psychological services. In the documentary *Gen Silent*, Lisa Krinsky of the LGBT Aging Project explains, "As they are older, there is a real mistrust of mainstream institutions" (Maddux, 2010, 0:16:51). If a queer elder previously came out they are invited back into the closets they spent formative years escaping from when entering residential care. If they have not come out before moving to an assisted facility, they are presented with the task of confronting overt and covert homophobia during some of the most vulnerable years of their adult lives. The lack of recognition, affirmation, and consideration of their lives leads to silence and invisibility that is detrimental to their physical and mental health as it would be to anyone of any age. Jones (2001) highlights challenges faced by queer elders explaining, "loneliness and health status, in particular, are themes that intersect differently for LGBT older persons" (p. 13). His work then connects the way systemic discounting of queer identity whitewashes personal identity and leads to mental health conditions including depression and alcoholism.

Another challenge to queer elders is that while the societal acceptance and acknowledgment of queer individuals has progressed among younger generations, the acceptance and acknowledgment of diverse communities, including queer-identifying peers among fellow non-queer elders, has progressed at a slower pace. This became evident to me at a weekly support I facilitate with seniors when one resident repeatedly described the gay characters on Will and Grace television show as "poofs." At another meeting a different group member referred to people of color on a sitcom as "Negroes." While inroads have been made within the younger community on civil rights and use of inclusive and respectful language toward queer, minoritized individuals, previous generations steeped in a white-centric, heteronormative culture often lack the respect or experience of many younger people. Systemic providers must remain aware of this dynamic because in most settings queer and minority elder residents reside in living arrangements within majority white, cisgender, heterosexual identified communities, a group who are often uninformed toward or inconsiderate of minority stress, social injustice, and macro/macroaggressions. Since Medicare and Medicaid provide little to no coverage for long-term care, most individuals in private pay elder housing come from financial means to pay for the service. These individuals are imbued with financial resources because they fit the prevailing white-centric, heteronormative social-cultural construct during their youth and were offered opportunities for acceptance, acknowledgment, and lucrative employment. In other words, private pay elderly housing is currently occupied by individuals who were offered the opportunities and advantages of a white-centric, heteronormative, and patriarchal informed society. They bring the expectations and biases of their youth to their current living situation. Minoritized hard-working individuals are excluded from these opportunities due to no reason other than society's biases that denied them access of white, heterosexual peers. Jasmine and Amanda were impacted by this dynamic in the following case example.

Case Vignette

In working with queer elders, I present an integrative model, grounded in systems theory, Narrative Family Therapy (White, 2004, 2007, 2009; White & Denborough, 2011) and Relational Life Therapy (Real, 1990, 1995, 2008, 2018). The case presented here is an amalgamation of several practice cases and incorporates principles of intersectionality in case assessment and treatment. Names and identifying characteristics are changed to preserve confidentiality. The four-step model outlined here includes:

1. *Joining and gaining case awareness.* Like many models of psychotherapy, the model begins by getting to know the client while the client gains a sense of ease and confidence in the therapeutic relationship. Queer stigma leads to internalized queer-phobia. This in turn impacts queer individuals to trust and fully express themselves. The impact of heteronormativity and minority stress on queer relationships and queer individuals trust process within relationships is detailed in work by Carvalho et al. (2011) and Frost and Meyer (2009). The psychotherapy community's support of and contributions to the debasement of queer individuals is documented and dates from the origin of psychoanalysis to conversion therapies performed in the present (Ashley, 2019; Smith et al., 2004). Through a sound and deliberate joining process, a clinician establishes comfort, relatability, and a relaxed atmosphere while beginning to learn about clients' unique life experience. A sound, careful, and deliberate joining process is critical to

establishing a trusting therapeutic alliance with queer elders, especially when we consider the historic wounds imparted on this generation by the psychotherapy profession.

2. *Utilizing an intersectional lens, meet the problem, identifying and acknowledging relational wounds promulgated by systems of oppression (i.e., heteronormativity, cisgenderism, ageism, racism, patriarchy, etc.).* Systemic therapists know that individual and relational health are interrelated; therefore, we help clients identify, understand, and claim previous relational wounds. Wounds are imparted through both individual interactions (one on one with supervisors, friends, or intimate partners), and perpetrated at the hand of larger institutional structures (e.g., treatment within schools, employment institutions). By maintaining an intersectional lens, we conceptualize the subsets of identity attributes that were discounted and disparaged by prevailing systems of power. During this stage the clinician is formulating a deepening hypothesis on how these wounds are internalized, introjected, and impacting the individual, their relationships, and the growth task at hand.
3. *Recognizing, naming, and fostering resilience within the client system*. As we disentangle previous relational wounds, we recognize and acknowledge the clients' strengths, affirming the power and potential of each client, recognizing that queer oppression offers positive impacts, gifts, and benefits. Queer individuals have unique experience discerning and claiming ownership of identity attributes disparaged and marginalized from their personhood. By claiming and integrating these parts, queer individuals exercise strength and resilience while claiming their truth with pride and power. In this step the clinician finds, practices, and uses those gifts to foster therapeutic change and empower the growth opportunity at hand.
4. *Building and reinforcing new strength-based narratives, and moving toward case closure.* As we move through the final step of the model, we recount and reinforce deepening awareness and a new narrative, one of strength, skill, and competence. We do this by synthesizing and claiming the problem narrative through the lens of the impact systems of the power rather than client pathology. We acknowledge that the problem's ownership and origin is "out there" in systems of power, and that clients' resolve and resilience is capable and responsible for their growth and empowerment.

Jasmine is a 75-year-old Black transfeminine woman in couple's therapy with her wife, Amanda, aged 65 of Latina descent. Jasmine was born in the United States (rural western Tennessee), born biologically male as Jeremy. Jasmine enlisted in the U.S. Army at 27 (as Jeremy) and served in the Vietnam War, seeing one year of intermittent "action" before discharge. Upon returning home to the United States, Jasmine settled in New York City, where she took up employment with the U.S. Post Office. Jasmine explored gender transition first at home, then in social situations (at home entertaining and nights out at queer-friendly establishments) followed by full-time transition at work and outside the home. In therapy she reported that her transition was socially demoralizing and that "I would not wish it on my worst enemy." She relayed instances when work colleagues harassed her asking, "What bathroom do you use, so I can stay away?" and "What did you do with your man-parts?" Despite being in New York City, a large diverse metropolitan center, outside of work she was also harassed and extremely aware of "double takes" she received which she interpreted to mean "People think I am a freak."

Amanda was born and raised in the Bronx of New York City and identified as a "typical Latina dyke." Employed as an airline call-center representative, Amanda reported a series of romantic partnerships (three live-in relationships, each with older women) that started well, but then progressed to what she called "emotionally volatile, bordering abusive." She

expressed pre-contemplative awareness around challenges she has speaking up for herself, "Sometimes I just clam-up"—a personality attribute that frustrates Jasmine.

Jasmine met Amanda at a fundraiser at the local gay/lesbian center and quickly married. After many years of living together and owning a home in Queens, they tired of the challenges of home ownership and mutually agreed to downsize and look at senior housing. Following an exhaustive search, they moved from New York City to the Connecticut shoreline, into an independent senior living community. "Even though we had to buy in and pay a monthly rent it was so much less expensive to live in Connecticut than own the house in Queens," they told me in our first session together. Initially, they were impressed with the sales staff's welcome and appreciation of their individual and collective queer identities. However, after settling into the facility they found fellow residents to be much less queer friendly/informed than the staff they initially interviewed with. "This ain't Queens, and this ain't got no queens," Jasmine told me as she contrasted their previous life in a cosmopolitan metropolitan city to residing in a residential senior community on the central Connecticut shoreline. They find some staff members, outside the initial sales staff, are not comfortable with their identities and relationship. Amanda is afraid Jasmine is depressed as she has become increasingly angry, despondent, and quick to trigger. After attending a senior citizen discussion group that I facilitated, the couple requested couple's therapy because they were uncomfortable with the increasing frequency and intensity of verbal arguments. Amanda said she no longer wants to be around someone who "makes me feel bad about myself." Jasmine stated that Amanda "won't take a stand with anyone" and that "she just drags her feet to make the smallest decision." Jasmine reported feeling angry and resentful because the staff led them to believe that they would feel welcome and valued where they live, and that is untrue. She stated, "They said anything they could to get us to come here and now don't give a shit." She expected Jasmine to speak up more when staff and fellow residents said something insensitive and blamed Jasmine for her difficulties, "Of course I am depressed, you don't stop people when they are saying offensive shit!" There were no reports of physical violence in the relationship. The couple is financially sound, one is currently employed and working from home, they have healthcare access, and they report good overall physical health. They take reasonably good care of their health, report no risky health behaviors, or non-prescription drug use, and require no service needs to support physical and mental functioning at this time.

We begin with *joining and assessment to gain case knowledge*. During the initial session, I explore family of origin and historic systemic interactions, creating a therapeutic alliance with the couple.

Therapist: So, I see you found me through The Advocate [a local queer-friendly publication]. I am curious about what you think of the paper?

Jasmine: I picked up a version of The Advocate back in the 1990s when I lived in New York, maybe even before, at a coffee shop in Westchester. I never even knew there was a thing called trans. I was depressed, anxious, and always doing things because I think I worried if I stopped, I would just, go crazy. I think finding that magazine saved my life. I read an advertisement from a doctor on trans health. I found home.

Amanda: I never knew that.

Jasmine: Yeah, honey there is a lot about me you don't know. Stick around.

Therapist: I would like to know more. I am curious how you both found each other.

Jasmine: Well when you grow up in west Tennessee and you are a like me you just run and get out. I was in the military young, and never had a reason to go back. But now we are living here and it feels like I'm back in hell all over again!

Therapist: It was hard to feel connected there and now it's hard to feel connected here?
Jasmine: It is hard for me to be connected everywhere. I am 75…and don't feel connected to anyone.
Therapist: I am sorry. Feeling disconnected is really hard.
Jasmine: Oh honey, I didn't even want to be connected to me.
Therapist: What does that mean?
Jasmine: I just knew I was different. I never knew why. My brother did things to me and mom was…just…drunk. I just got out.
Therapist: To Vietnam.
Jasmine: Anywhere I could. That was my ticket out. I could fight and hold my own in a war. I am just sick of fighting, and last thing I thought was I would have to fight once I got here.
Therapist: So it sounds like home was not an easy place. And now you're here, and it feels unwelcoming.
Jasmine: Yup.

Here we see joining, creating an alliance, and beginning to explore the client's relationship to inclusion and exclusion. Jasmine relays an early home life of abuse at the hands of her brother and emotional absence of her mother. Going to Vietnam was more appealing than staying in relationship with family. Her current relationship with fellow residents is unfulfilling and reminiscent of previous unfulfilling social situations and interactions. I remain cognizant that, so far at least, Jasmine is more inclined to speak than Amanda. The session continues.

Therapist: So you are from western Tennessee. I know nothing about that part of the United States.
Jasmine: Well it wasn't all that. It was just hard, mostly my brother. He's dead though.
Therapist: Oh, I am sorry about that loss.
Jasmine: Oh, it is quite OK.
Therapist: And Amanda what about you? What can you tell me about you?
Amada: Well, NYC Bronx is where it was for me. That is really it.
Therapist: And I am curious about your early life?
Amanda: That was a long time ago. My mother was from Puerto Rico and thought being a mom meant telling me what to do, who to be, what to wear, and how to act. She was nice but always in my business. She worked cleaning houses and gave us a living. She was hard.
Therapist: Oh, is she still in the Bronx?
Amanda: She died five years ago. But I didn't talk to her for a while [pauses]. Once I came out, she kept trying to Jesus me back into having a man.
Therapist: Well, you are in Connecticut and [looking at Jasmine] I see how the rest went (laughs).
Amanda: Well she never really wanted to listen…just talk and tell me what to do. She was hard worker. But she never heard a word of me. Now it just feels like that all over again.
Therapist: So mom never heard a word?
Amanda: Never. And [said softly as she points to Jasmine] she can't listen either.
Jasmine: Oh, I can honey. Just watch me listen to you.

In this exchange we see themes that will emerge and be investigated in subsequent sessions. Jasmine and Amanda frame a narrative of past relationships through a somewhat similar lens, one of isolation, oppression, and indifference (vis-à-vis family members, past relationships, and current community interactions). As a result, they often did not feel heard, acknowledged, or affirmed in relationships with others.

Once joining and gaining awareness of how these clients experience the problem, we use an intersectional lens to meet the problem, identifying and acknowledging relational wounds promulgated by systems of oppression. The client and therapist deconstruct specific situations

to discern the dynamics of oppression and the experience on the individual and the couple. These dynamics of disempowerment have an impact on relational skills; one can become overly self-sufficient and over-estimate one's skills and self-worth, or undervalue one's identity and self-worth (Mellody et al., 2003; Real, 2008, 2018). The following exchange takes place in mid-treatment. The depth and intensity of the couple's exchanges has deepened and the impasses within their relationship and the contributing systemic influences have become clearer. While they both acknowledge love and devotion to one another, they are also frustrated because the relationship is filled with "more augments than support." In the next segment, we look at a composite of intersectional wounds and experiences. The resulting and prevailing dominant story of the clients is influenced by themes of devaluation and dehumanization, a theme currently activated by fellow residents' treatments and responses toward Jasmine and Amanda.

Amanda: I try to support her but everything I do is met with an attitude.

Jasmine: You do not need to help me. You can't help me. You can't even help yourself, baby. You have no ability to speak up when you need to. Take care of yourself honey, I'll take care of me. Talk to your boss about the way she talks to you. Talk to Mrs. Buttons about giving us the silent treatment every night at dinner. I took care of me in action and at the Post Office. Shit, I fought from day one and keep fighting here. This place was a big fucking mistake. I do not need you or anyone, so go and take care of yourself.

Amanda: Well what kind of relationship is that.

Jasmine: It just is what it is, hon.

Therapist: OK. Can I stop here for a bit? I see how much care for one another. And then I see when these moments of frustration and missed connection arrive. This missed connection is hard. It is hard to watch, and I can only imagine what it is like for the both of you.

Amanda: [looks down] It sucks.

[pause]

Jasmine: [consolingly] I love you boo.

Therapist: Jasmine. I want to start with something that you said, "I do not need you to help me." Can we look at that?

Jasmine: Sure. I don't need her. I didn't need my mom, didn't need my brother. I need no one. [She looks at Amanda] Hear me, NO ONE.

Therapist: Yeah that sounds hard…I am so sorry.

[pause]

Therapist: So I am thinking something. Do you want to know what it is?

Jasmine: Oh, go ahead.

Therapist: Follow me for a moment. I am seeing a person similar to you. Let's imagine she's a woman, a character in a book. And in her story, she grew up and went into war. Her brother didn't value her worth, did really ugly things to her, and her mother didn't protect her from her brother. Her mother drank. And in this story, she keeps going into battle. First, she went to war and fought in literal battle. Then she transitions gender and fights the coworkers who don't understand her and gave her shit. And then she moves to a place she thinks is going to be safe, and it's another battle all over again. So there are all these parts of this story, and each part she fights. She's a soldier.

Jasmine: And a damn good one. Seventy-five years old and I am still fighting. I am so fucking tired of fighting.

Therapist: Yes, the best soldier can't fight alone…How do you feel right now?

Jasmine: I am just pissed off and angry that so few people get me. That so few people understand what it feels like. I am so pissed off and she [points to Amanda] just sits back with her head up her ass.

Therapist: It makes sense that you feel angry. You carry so much, and so well. When you look back what do you think was the first battle that soldier fought?
Jasmine: When her brother did what he did to her.
Therapist: And who took care of her. Where was her so-to-speak "commanding officer" to take care of her and watch her.
Jasmine: You mean my mother? With her head completely up her ass?
Therapist: Right. [pause]
Jasmine: But she needs to speak up and fight!
Therapist: Different soldiers fight different ways, maybe. Some fight and charge the front lines. Some are more comfortable quiet and behind enemy lines.
Jasmine: Maybe.
Therapist: And maybe soldiers are stronger when they stick together.
Jasmine: Good ones.
Therapist: I am wondering if you consider for a minute those things happened to that character… They were not fair, and they were not her fault. There are many people in that story who did not honor her and who did not help her when she needed it.
Jasmine: No. They did not.
Therapist: And where does that leave her?
Jasmine: Alone.
Therapist: And maybe that story could change if she found someone to fight alongside…soldiers-in-arms. Like you two here, Jasmine and Amanda, can feel stronger beside one another. Soldiers and women-in-arms. Maybe that is where you are two moving toward…Loving arms. For fighting, and caring, love, and support. How would that feel?

Here, using a story, I explore the intersectional stresses and challenging identity attributes that Jasmine experienced. I find story metaphors, similar to Bowenian displacement stories, helpful with clients who have trauma history, and quick to react in amygdala managed "fight-or-flight" response. The story metaphor personalizes Jasmine's experiences and, at the same time, depersonalizes it. The clinician is attempting to foster openness and non-reactivity by making it about Jasmine, yet somewhat distinct from her. Jasmine experienced repeated relationships that did not protect her, and that threatened and devalued her worth. Jasmine disclosed an abusive relationship at the hands of her brother, repeated instances of direct and indirect discrimination for her Black identity, and years of gender dysphoria before being finding a conceptualization for understanding and accepting her trans identity, a victim of haggling and abuse at work from a boss and co-workers. Currently she lives in an environment with people who frequently do not engage or acknowledge her. These intersectional identity attributes and situations support a dominant story experienced as one of rejection, exclusive reliance on self for protection, and trauma at the hands of others. In Jasmine's story, relationships do not generally bring trust and validation, rather threat and the potential to feel scorned, even targeted. Transgender individuals receive macro- and microaggressions in a society that heavily invests in preserving a gender binary and as a result over-values masculinity and devalues them. The very existence of transgender and gender expansive people challenges the cultural status quo threatening established power structures and therefore results in discrimination and prejudice as a result of a prevailing systemic binary orientation (it must be this or that). Racism, patriarchy, and systems of power contribute to her oppression. Jasmine's minoritized identity is a critical intersectional attribute to consider, especially since trans woman of color experience increased debasement, hostility, and violence compared to other queer individuals (Waters & Yaka-Bible, 2017). Multiply this by her experience in the world as a queer elder where being discounted

and disregarded in current settings remind her of previous emotional injuries. Elders are not asked about aspects of their identity such as sexuality and gender identity. Like children, they are viewed as without functioning genitals, lacking sexual orientations, fantasies, and/or proclivities. In the previous section, we highlighted that in the process of finding her transgender identity, different relationships could not or would not nourish and support her identity. Staff and fellow residents in their housing community are not willing or able to acknowledge and support Jasmine and Amanda's queer identity. Yet the possibility exists to create and foster her relationship with Amanda, to write a new narrative moving forward. Jasmine and Amanda have an opportunity to be more unified as a couple and more supportive of themselves, individually and collectively. In the next segment, we examine Amanda's history and experience.

Amanda: I just do not see why my boss gives me that attitude. I meet my stats and get good post call reviews, yet all she does is put me down on conference calls.
Jasmine: [pointing at Amanda] You take too much shit!
Amanda: I do. I am so frustrated.
Therapist: I am wondering what you think Amanda should do.
Jasmine: I think she should step up and tell her boss to go fuck herself.
Amanda: I can't.
Jasmine: Or you won't!
Therapist: Amanda what do you think you would like to do.
Amanda: I need to speak up. It's just too much sometimes and having her [Jasmine] yell at me… [she trails off].
Therapist: I wonder if it would feel safe to tell that to Jasmine.
Amanda: What?
Therapist: I wonder if you could say what you just said to me to Jasmine. If that would be OK to try, or if it feels like too much.
Amanda: What did I say?
Therapist: Something like "Jasmine, what you are doing is not helping. Please stop yelling." I think you might have said something like that.
Amanda: [softly] That would be scary.
Jasmine: You are small. Just say it! He said say it. It's like what happens with Mrs. Buttons. You don't say anything. That's why I don't trust you. You let people walk all over us.
Amanda: I speak up.
Jasmine: No.
Amanda: [retracts in her seat, head lowers and, speaks softly] I do. It's just hard.
Jasmine: Oh please. Stop.
Therapist: Can we stop for a moment [and] take a look at this?
Jasmine: OK. Let's stop.
Therapist: I have learned about how Amanda felt her mother discarded and discounted her identity when she told her who she was. Jasmine you told me about how Amanda was alone and in a series of relationships that abused her, relationships that cut her off from other friends. I know a bit about her and how she started community college and felt out of place, how she felt because she was a lesbian, and not comfortable sharing that, how she framed herself as "a freak." In two jobs she was fired even though she was doing a good job, and how people look at her "funny" because she does not act like a "dainty chick," and how she felt compelled to talk "white" and "educated" and act a certain way in different workplaces or different interactions.
Jasmine: She needs to fight!

Therapist: Amanda, what do you think you need from Jasmine?
Amanda: Just…stop. Quit flying off the handle. Just…talk.
Therapist: I am wondering about something. You both have experienced when people yell and put you down directly and to your face. Amanda that seems to happen at work, sometimes Jasmine raises her voice at you. Jasmine, I seem to remember you had that happen at the post office. Now here you both live in a place where people disregard you, they don't talk to you, and if they do, they talk pleasantries, nothing of real substance. In one scenario, they are aggressing with raised voices. In the other they are ignoring or neglecting you because you are different. I would like to ask the two of you to talk about how you both would like to manage difference—differences of opinion, differences in the way you think and act—in this relationship. Maybe think about the way you want to show up for yourself and for each other. Would you be willing to try that?
Amanda: I do not want to be yelled at or ignored.
Jasmine: I don't want to feel left out and alone.
Therapist: Let's see what alternatives you both can think of.

Here we are highlighting intersectional aspects of identity and situational stressors, then assessing the cumulative impact this narrative has had on Amanda. Amanda presents as intelligent, lively, and quick-witted when comfortable. In times of conflict and overt discord, she retracts. Amanda was physically and emotionally abandoned by her mother when she disclosed her sexuality and continued to unapologetically own and present herself as a lesbian. When Amanda insisted her sexual orientation was not going to change, her mother became more disparaging until Amanda ceased contact with her. She learned through an aunt of her mother's sudden passing. A series of romantic partnerships started with optimism, mutual support, and potential happiness. Yet eventually in each of her three long-term relationships, abuse emerged. She gave (and gives) tremendously at work, yet consistently felt/feels unacknowledged and underappreciated. The "silent treatment" and lack of resident and staff support coupled with her job experiences continue to support that narrative. The clinician hypothesizes that her relationship with Jasmine has similarities to previous relational experiences where individuals and institutions have discounted her skills and abilities, and that a feedback loop develops in which Amanda retracts from conflict, escalating the relational partner. As a result, Amanda retracts further and the cycle escalates. The clinician hypothesizes that Jasmine promulgates a narrative of self-sufficiency—better than and above others—a relational dynamic Terry Real defines as a relational "one-up" or "grandiosity." Amanda, however, has propensity to go to a position of emotional "less-than," what Real calls a "one-down" position or a position of shame (Mellody et al., 2003; Real, 2008, 2018). The stress of feeling discounted and unaffirmed within their housing community is relational wounds reminiscent of and as impactful as past relational injustices. As this portion of the session closes, we introduce the dichotomy between outright aggression, belittling and discounting, and the impact of disregarding, ignoring, and neglecting. Both are damaging to relational processes and mental health. The intervention at the end of this segment proposes alternatives to how Amanda and Jasmine could and might react when difference and discord are evident within their relationship.

Once we have unpacked and deconstructed prevailing and preexisting narratives, we focus on *recognizing, naming, and fostering client strengths and resilience*, dislodging and deflating narratives and injuries imparted through systems of power. This is accomplished by understanding previous situations and dynamics that were steeped in systems of oppression that negatively impacted the client. Then, using a strength-based perspective, we look for opportunities and tasks that reclaim power while we build upon existing coping skills and

strengths. Mindful of an intersectional lens directed toward self, we attempt to consider attributes and beliefs that may be outside our awareness as members of a more privileged subset of society (potentially contributing to retraumatizing clients). For example, I question whether as a gay, white, cisgender, male, and younger individual than my clients, I am seeing and considering Jasmine and Amanda's full experience? Intersectionality means a both/and approach. Supervision and peer consultations assists in bringing awareness to what the case clinician may be unaware of.

Jasmine and Amanda attended 17 sessions of couple therapy. Jasmine is beginning to understand how her vocal fortitude, outspokenness, and "frontal attack" approach to conflict is, in many instances, an unproductive coping strategy originally developed to prevent her from further hurt. She is beginning to understand how the narrative of invincibility and grandiosity she creates is negatively impacting herself and her relationship with Amanda. While examining this, we remind her of the good this behavior has provided her, the way it was originally needed to keep her safe and sheltered during unhealthy and disaffirming interactions. Jasmine has multiple strengths including the ability to draw boundaries, define differences, and self-advocate. Counter to Jasmine's coping skills, Amanda shuts down and goes "one-down" and into a shame-based stance during conflicts. Amanda's narrative consists of a story that she is incapable and unworthy of speaking up for herself. Amanda is beginning to recognize her propensity to "shut down" more immediately within an interaction. While this way of reacting served and protected her in the past, it no longer does so. It is a strength in that she can remain agreeable, understanding, and open. As Amanda practices her emerging psychological strength, individually and relationally, she elects how to show up in each particular interaction and relationship. This might be understanding and accommodating or respectfully asking for what she needs. She has more choices and as a result an enlarged emotional presence in her relationships. During the next segment, we explore alternative options to Jasmine's and Amanda's previous coping strategies.

Therapist: Can I say something?

Jasmine: Please do. That's why we pay you.

Therapist: I wonder if you both have a story, and that story says that Amanda is incapable of fighting for herself. She was hurt and let down by many people: her mother, her ex-partners, work place environments, people at the community college treated her differently because she was a Latina and a woman who loves women. So, Jasmine, you step in, and you care about her. There's a story that says she's weak and incapable. Does that sound like a story either of you have?

Jasmine: [interrupts] She is.

Therapist: And here's the thing. What if there is a common story here? What if she is scared and her scared part, her child part tells her a story that she is weak, and she backs down. And your story, your scared part, your child part, calls you into action, to mobilize guns and reaction. To fight. And underneath both stories are these scared parts, these child parts, that you both share. If that is true, maybe there is a way to take care of each other's scared parts, rather than further damage them. What do you think of that? That you could both be each other's allies? Sounds like in some of the interactions here, with other residents, you use an ally.

Jasmine: She just backs down!

Therapist: I am afraid you might not be taking this in and getting your money's worth. You are paying me after all.

Jasmine: [slows down and says softer]. No, no. I get it.

Therapist: I am wondering if the two of you actually have more in common than you think, in the ways to help each other with the way people respond to you here. And that maybe you are learning to show up and guard each other's flank. You could defend and honor one another or cause collateral damage and friendly fire. A lot of couples who were hurt by others have to learn not to hurt each other. They share common enemies: disregard, lack of acknowledgment, and discrimination from others. Maybe those are their real enemies. And you are each other's allies. I wonder how does that sound?
Jasmine: It sounds healthy to have each other's back.

As changes take root, we move into the final stage of treatment, *build on new strength-based narratives, and move toward case closure*. The potential to see oneself as developing and emerging, with self-consideration, self-compassion, and without self-criticism about past relational failures nurtures the potential to build and reinforce strength-based narratives. In this stage, the queer elder understands the systematic oppressions of the past and the ways systems of power contributed to these dynamics. Through this understanding and owning new narratives, they move toward greater self-advocacy and self-esteem. Paradoxically, greater self-awareness and increased strength accompanies greater humility and comfort with self-doubt. The clients' capacity for vulnerability coupled with greater self-awareness increases the capacity for growth. As we begin to consider case termination, we prepare the client for challenges to newly emerged belief systems in order to normalize episodes of self-doubt and the potential resurfacing of past narratives. Using an intersectional lens, we facilitate clients seeing themselves as complex non-binary amalgamations, as strong and vulnerable individuals. Each of these parts contributes to greater levels of personal understanding and heightened ownership of personal power. Jasmine and Amanda share similarities and differences. Amanda's shutting down and Jasmine's outspokenness complement one another, yet emerged from shared origins, the impact of oppression, patriarchy, and relational wounds. In the following exchange, Jasmine and Amanda are commenting on changes that have worked, and things that are still frustrating to them individually and collectively. As they explore how to show up more productively for each other, they ask for what they need from each other and fellow residents. They demand the respect and acknowledgment they deserve by requesting it with curiosity, respect, and confidence.

Jasmine: I think sometimes I am cooler now. I am less likely to go off the rails. I think my classes help [she began taking exercise classes offered in the residents' club house].
Amanda: I think I am better at letting you know when you are just too much.
Therapist: I am wondering what you are learning individually and from each other.
Jasmine: I think I am learning that not every relationship is one that is going to let me down and frustrate me. I think I am learning to trust more. I think I am learning Amanda has my back. She teaches me that you can fight but not go all out "shock and awe." She has her own way, her own time to get to it. I just need to wait for it.
Therapist: Who do you think you are you learning to trust?
Jasmine: Her.
Therapist: And who else, maybe?
Jasmine: Who? Me?
Therapist: What do you think?
Jasmine: I think so. Yeah. I think sometimes I wait for the shoe to drop and do this whole "Don't fuck with me. I'll fuck with you first." And hell, if someone gives me shit, I can give it back. But I don't need to start there. Just yesterday in [exercise] class someone said something that implied that all couples are hetero. I forgot exactly what it was and I

spoke up and said that I felt excluded and just said "excuse me?" I was surprised when Marlene came up after class and apologized.

Therapist: Not every person is the enemy? And it is nice to know that if someone does give you lip, you are prepared and have the skills to say, "Stop please."

Amanda: I didn't know I had a right to exist. I couldn't ask for what I needed. And then this place and moving here just made it all the worse. It's still hard sometimes. I think she teaches me that I can speak up, and show up. And even if it is hard, it helps when I do. I can say this doesn't feel right. I have a right to have a voice. I was with Mrs. Button the other day at the supper table and she said "Where is your husband?" Now in the past I wouldn't have spoken up, I would have changed the pronoun for her. But this time I said "Not everyone is cursed with a husband, Arlene. My wife is coming down in a few minutes." That shut her up.

Therapist: Wow! I wonder what you both think of that?

Jasmine: You ain't taking anyone's shit! Honey, you ain't takin my shit! [laughs]

In this exchange, we explore responses between Jasmine and Amanda and the way they respond to others. We remain mindful of supporting successes, coaching, and allowing clients to strategize when things go wrong or revert to old narratives. We support Jasmine as she explores not reacting and going into an anticipatory fight response. We support Amanda as she explores ownership of a narrative that maintains engagement in the conversation and avoiding a presumptive "one-down" response. As a result, the couple has greater role fluidity with the choices they have within new roles and narratives, both with one other, and with residents where they live. They build on owning and bringing their queer identity to staff and residents in relationally equal "eye-to-eye" interactions.

In the past, Jasmine readily reacted with dominant, one-up responses, while now she has greater access to choose softer responses. In the past, Amanda readily assumed passive and powerless roles, and now she possesses greater access to putting her needs and voice forward with confidence, timeliness, and fluidity. The therapist and couple will continue to explore the couple relationship, supporting successes and challenging resurgent unproductive narratives rooted in systems of power, racism, and patriarchy. Outside the work done in couple sessions, the couple requested a meeting with the executive director and activities director of their residential community. They shared their feeling of exclusion and asked the community to offer more varied media programming in social functions. For example, films shown each "movie night" were mostly released between the 1950s and the 1970s. While these titles had familiarity with the residents, they prominently featured white, heterosexual characters. Jasmine and Amanda proposed and the residential staff purchased films with characters that represented people closer to Amanda and Jasmine, including people of color, people of different sexual orientations and gender expressions. They also requested that staff treat them like every other resident, and acknowledge their relationship similar to the heterosexual couples within the resident community. The facility agreed to offer diversity trainings to address Amanda and Jasmine's concerns. Amanda and Jasmine left couples counseling with an enlarged skill set, yet like any couple system, they hardly perfect and free from tension. The door remains open and our profession remains available when and if they request additional services.

Conclusion

Queer elders are a resource within the community at large. They surmounted challenges amidst a society that often views them as disposable and undesirable. As such, queer elders are a reminder that challenges, burdens, and crises have potential to crystalize strength and resilience and move us toward greater actualization. Amanda and Jasmine were victims of traumatic, unjust, racist,

sexist, and heteronormative burdens that impacted them individually and collectively resulting in coping actions and reactions that hurt themselves and each other. Their move to a residential community catering to the elderly put burdens on their relationship based in heteronormative and white-centric expectations. Yet, Jasmine and Amanda's challenges brought opportunities to heal, unlearn, and relearn. Wounds established through systems inculcated with racism and patriarchy have potential, when claimed and liberated, to foster self-connection and commitment to self-acceptance, self-compassion, and empowerment. This claiming and liberating also has potential to change others and the world at large because the understanding of diversity in one context has potential to increase understanding of diversity in another setting. It is not my intent to justify, diminish, or glorify systemic injustices, rather to iterate that meaning and personal empowerment may be claimed under these conditions. Repeated works of psychotherapeutic literature contain examples of the potential for healing and actualization in response to loss, suffering, and psychological pain (Breitbart et al., 2004; Frankl, 1963, 1997; Satir, 1988).

Systems of power such as racism, heteronormativity, and patriarchy stifle identity, instill rigid rules and roles, and disenfranchise those distal to positions of authority and power. By utilizing an intersectional affirmative model of treatment, we call attention to the personal and relational strengths of queer elders. All individuals, queer and non-queer, young and old, white and Black, embody complex amalgamation of influences, experiences, and coping responses, which when we get to know make sense and contribute to understanding the beauty of their lives. As such, systems-based clinicians have unique understandings and talents to offer queer elders. Here I propose a systems model, cognizant of the principles of intersectionality, integrative of narrative family and relational life therapy, and informed by considerations of abusive systems of power. Relationships have potential to harm and heal, to strengthen or hamper trust in self and others. The task of the systemic therapist working with queer elders is to consider the holistic summation of societal and relational influences (mindful of the past and present), to meet them with understanding and respect, and to cultivate client understanding of the current and potential future narrative. This understanding fosters opportunities to relate to self and others with respect, acceptance, and compassion—in other words, what every human being is entitled to, particularly in old age.

References

Adames, H. Y., Chavez-Dueñas, N. Y., Sharma, S., & La Roche, M. J. (2018). Intersectionality in psychotherapy: The experiences of an AfroLatinx queer immigrant. *Psychotherapy, 55*(1), 73–79. https://doi.org/10.1037/pst0000152

Addison, S. M., & Coolhart, D. (2015). Expanding the therapy paradigm with queer couples: A relational intersectional lens. *Family Process, 54*(3), 435–453. https://doi.org/10.1111/famp.12171

Ashley, F. (2019). Homophobia, conversion therapy, and care models for trans youth: Defending the gender-affirmative approach. *Journal of LGBT Youth.* https://doi.org/10.1080/19361653.2019.1665610

Avery, D. (2019, April 19). 71 Countries where homosexuality is illegal. *Newsweek*. https://www.newsweek.com/73-countries-where-its-illegal-be-gay-1385974

Branson-Potts, H. (2014, April 20). For LGBT seniors, affordable housing is scarce and often unwelcoming. *Los Angeles Times*. https://www.latimes.com/local/la-me-gay-elder-housing-20140420-story.html

Breitbart, W., Gibson, C., Poppito, S. R., & Berg, A. (2004). Psychotherapeutic interventions at the end of life: A focus on meaning and spirituality. *The Canadian Journal of Psychiatry, 49*(6), 366–372. https://doi.org/10.1177/070674370404900605

Brown, M. T. (2009). LGBT aging and rhetorical silence. *Sexuality Research & Social Policy: A Journal of NSRC, 6*(2), 65–78. https://doi.org/10.1525/srsp.2009.6.4.65

Carvalho, A. F., Lewis, R. J., Derlega, V. J., Winstead, B. A., & Viggiano, C. (2011). Internalized sexual minority stressors and same-sex intimate partner violence. *Journal of Family Violence, 26*(7), 501–509. https://doi.org/10.1007/s10896-011-9384-2

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum, 1989*(1), 139–167.

Department of Defense. (1993). *Don't Ask Don't Tell.* Directive 1304.26.
Frankl, V. E. (1963). *Man's search for meaning: an introduction to logotherapy*. Washington Square Press.
Frankl, V. E. (1997). *Man's search for ultimate meaning*. Insight Books/Plenum Press.
Frost, D. M., & Meyer, I. H. (2009). Internalized homophobia and relationship quality among lesbians, gay men, and bisexuals. *Journal of Counseling Psychology, 56*(1), 97–109. https://doi.org/10.1037/a0012844
Gaddis, S. M. (2015). Discrimination in the credential society. *Social Forces, 93*(4), 1451–1479. https://doi.org/10.1093/sf/sou111
Grossman, A. (1997). The virtual and actual realities of older lesbian and gay men. In M. Duberman (Ed.), *A queer world: The center for lesbian and gay studies reader* (pp. 615–626). New York University Press.
Harvey, R., Stone Fish, L., & Levatino, P. (2020). Sexual identity and heteronormative development. In K. Wampler & M. McWey (Eds.), *The Handbook of Systemic Family Therapy* (Vol. 2). Wiley.
Hu, W. (2017, July 3). Creating a home for L.G.B.T. seniors in New York City. *New York Times*. https://www.nytimes.com/2017/07/03/nyregion/housing-lgbt-seniors-new-york-city.html
Jones, B. E. (2001). Is having the luck of growing old in the gay, lesbian, bisexual, transgender community good or bad luck? *Journal of Gay & Lesbian Social Services: Issues in Practice, Policy & Research, 13*(4), 13–14. https://doi.org/10.1300/J041v13n04_02
Kang, S. K., DeCelles, K. A., Tilcsik, A., & Jun, S. (2016). Whitened résumés: Race and self-presentation in the labor market. *Administrative Science Quarterly, 61*(3), 469–502. https://doi.org/10.1177/0001839216639577
Kattari, S. K., Whitfield, D. L., Walls, N. E., Langenderfer-Magruder, L., & Ramos, D. (2016). Policing gender through housing and employment discrimination: Comparison of discrimination experiences of transgender and cisgender LGBQ individuals. *Journal of the Society for Social Work and Research, 7*(3), 427–447. https://doi.org/10.1086/686920
Knauer, N. J. (2009). LGBT elder law: Toward equality in aging. *Harvard Journal of Law and Gender, 32*(1), 1–58.
Kuper, L. E., Wright, L., & Mustanski, B. (2018). Gender identity development among transgender and gender nonconforming emerging adults: An intersectional approach. *International Journal of Transgenderism, 19*(4), 436–455. https://doi.org/10.1080/15532739.2018.1443869
Maddux, S. (Director). (2010). *Gen silent* [Film]. The Clowder Group.
McCall, L. (2009). The complexity of intersectionality. In E. Grabham, D. Cooper, J. Krishnadas, & D. Herman (Eds.), *Intersectionality and beyond: Law, power and the politics of location* (pp. 1771–1800). Routledge-Cavendish.
Mellody, P., Miller, A. W., & Miller, J. K. (2003). *Facing codependence: What it is, where it comes from, how it sabotages our lives*. Harper & Row Publishers.
Olzak, S., & Ryo, E. (2007). Organizational diversity, vitality and outcomes in the civil rights movement. *Social Forces, 85*(4), 1561–1591. https://doi.org/10.1353/sof.2007.0076
Oreopoulos, P. (2011). Why do skilled immigrants struggle in the labor Market? A field experiment with thirteen thousand resumes. *American Economic Journal: Economic Policy, 3*(4), 148–171. https://doi.org/10.1257/pol.3.4.148
Real, T. (1990). The therapeutic use of self in constructionist/systemic therapy. *Family Process, 29*(3), 255–272. https://doi.org/10.1111/j.1545-5300.1990.00255.x
Real, T. (1995). Fathering our sons: Refathering ourselves: Some thoughts on transforming masculine legacies. In K. Weingarten (Ed.), *Cultural resistance: Challenging beliefs about men, women, and therapy* (pp. 27–43). Harrington Park Press/Haworth Press. https://doi.org/10.1300/J086v07n01_04
Real, T. (2008). *New rules of marriage: What you need to know to make love work*. Ballantine Books.
Real, T. (2018). *Fierce intimacy: Standing up to one another with love* [Audiobook].
Satir, V. (1988). *The new peoplemaking*. Science & Behavior Books.
Schope, R. D. (2005). Who's afraid of growing old? Gay and lesbian perceptions of aging. *Journal of Gerontological Social Work, 45*(4), 23–39. https://doi.org/10.1300/J083v45n04_03
Shenkman, G., Ifrah, K., & Shmotkin, D. (2018). The association between negative attitudes toward aging and mental health among middle-aged and older gay and heterosexual men in Israel. *Aging & Mental Health, 22*(4), 503–511. https://doi.org/10.1080/13607863.2016.1274374
Shenkman, G., Ifrah, K., & Shmotkin, D. (2020). Interpersonal vulnerability and its association with depressive symptoms among gay and heterosexual men. *Sexuality Research & Social Policy, 17*(2), 199–208. https://doi.org/10.1007/s13178-019-00383-3
Smith, G., Bartlett, A., & King, M. (2004). Treatments of homosexuality in Britain since the 1950s—an oral history: The experience of patients. *BMJ*, *328*(7437), 427. https://doi.org/10.1136/bmj.328.427.37984.442419.EE

Sultana, A. (2012). Patriarchy and women's subordination: A theoretical analysis. *Arts Faculty Journal, 4*, 1–18. https://doi.org/10.3329/afj.v4i0.12929

United States. (1996). *Defense of Marriage Act: Report together with dissenting views (to accompany H.R. 3396)*. (United States Congressional serial set vol. 14375.) Washington, U.S. G.P.O.

Waters, E., & Yaka-Bible, S. (2017). *A crisis of hate: A mid year report on homicides against lesbian, gay, bisexual and transgender people*. http://4cv6673q3rq92smo7p3grp2z-wpengine.netdna-ssl.com/wp-content/uploads/2017/08/NCAVP-A-Crisis-of-Hate-Final.pdf

Weeks, J. (1981). The problem of older homosexuals. In J. Hart & D. Richardson (Eds.), *The theory and practice of homosexuality* (pp. 177–184). Routledge.

White, M. (2004). Folk psychology and narrative practices. In L. E. Angus & J. McLeod (Eds.), *The handbook of narrative and psychotherapy: Practice, theory, and research* (pp. 15–51). Sage.

White, M. (2007). *Maps of narrative practice*. Norton.

White, M. (2009). Narrative practice and conflict dissolution in couples therapy. *Clinical Social Work Journal, 37*(3), 200–213. https://doi.org/10.1007/s10615-009-0192-6

White, M., & Denborough, D. (Eds.). (2011). *Narrative practice: Continuing the conversations*. Norton.

Zhao, X., & Biernat, M. (2017). "Welcome to the U.S." but "change your name"? Adopting Anglo names and discrimination. *Journal of Experimental Social Psychology, 70*(1), 59–68. https://doi.org/10.1016/j.jesp.2016.12.008

Taylor & Francis
Taylor & Francis Group
http://taylorandfrancis.com

19

Where Should We Go to Church? Or Should We Even Bother

Spirituality and Religion in LGB Couples' Therapy

STEVEN D. JOHNSON, SHARON S. ROSTOSKY, and ELLEN D. B. RIGGLE

Lisa and Michelle make an appointment with a therapist because of issues surrounding their spirituality. Lisa grew up attending an AME (African Methodist Episcopal) church in a small town in Ohio. Her uncle was the minister of the congregation and her family attended church several times a week. Similar to other African American families where she grew up, the church was a central part of family life and a dynamic of Lisa's childhood. Michelle, on the other hand, attended a Catholic church only a few times each year. She was raised in a large city in Ohio and attended a parochial school run by the local Catholic parish. Michelle is white and the congregation was predominately white with some Latinx members. Michelle admits that she never really connected with the Catholic faith, and her memories of church are more about how controlling and punitive the church could be. Neither Michelle's nor Lisa's church was open and affirming of LGB couples. However, they have recently adopted two-year-old son, and Lisa feels strongly that they should raise him in a church. Michelle sees no reason to give up her Sundays to be around a bunch of people who think it is wrong to be gay and who do not support their relationship. Michelle remembers strong feelings of oppression surrounding her experiences with the church, particularly during her adolescence when she began to recognize her attraction to other females. Lisa understands and empathizes with Michelle's feelings, but she feels equally strongly that it is important that they connect with a religious community. Their differing perspectives are putting a significant strain on their relationship.

Spirituality may be defined as the human pursuit of meaning, purpose, and committed action in response to existential questions such as "Why are we here? What is worth living for?" (Walsh, 2013). Although many LGB couples enact their spirituality through specific religious traditions and belief systems, spirituality, as a facet of human experience, does not require institutionalized forms of religion or a belief in any metaphysical entity. Religiousness, however, can be defined as the extent to which an individual believes, follows, and practices a religion (Koenig et al., 2012). Both spirituality and religiousness may influence how people seek to live out their lives and treat others.

Distinguishing between spirituality and religiousness may be particularly important when working with lesbian, gay, and bisexual (LGB) individuals. In recent samples of LGB individuals, the majority reported being unaffiliated with any religion, yet being at least somewhat spiritual (Barnes & Meyer, 2012; Rodriguez et al., 2019). In the 2014 Religious Landscape study, 41% of LGB survey respondents (compared to 22% of heterosexual respondents) indicated that they had no religious affiliation. LGB survey respondents were less likely than heterosexual respondents to identify as Christian (48% vs. 71%) and more likely to identify with a non-Christian religion (11% vs. 6%; Pew Research Center, 2015).

DOI: 10.4324/9780429274626-24

Religious participation may vary across the family life cycle. Young adults may have little interest in religious participation prior to becoming parents. Like different-sex couples, LGB couples may be more likely to seek out spiritual resources and communities to support their parenting and provide a sense of community for their families, although little research exists to formally support this idea (see critique in Mahoney & Krumrei, 2012, calling for more research on religious familism in LGB families). Some survey findings suggest that as lesbian, gay, bisexual, transgender, and queer (LGBTQ) adults move into their later years, they may look to their religious communities for social, spiritual, emotional, and practical support for dealing with aging, caregiving, and end-of life issues (Brennan-Ing et al., 2013). LGBTQ people may identify as religious, spiritual, both, or neither. While the psychological literature frequently conflates or uses the terms religion and spirituality interchangeably, it is important for therapists to distinguish these constructs in their conceptualization, assessment, and treatment of spirituality in couple's therapy.

For many couples, religious beliefs and traditions may either pose challenges to healthy functioning or provide a source of strength and support. In psychotherapy, an LGB couple may need to address both sides of this coin. That is, many (but certainly not all) partners are likely to have had experiences in which religious beliefs were used as a justification for discriminating against and even rejecting their individual and couple identities, but may also seek out religious community for support.

Affiliation with a non-affirming religious institution has been associated with internalized stigma, a minority stressor that can negatively affect individual psychological health and relational well-being (Barnes & Meyer, 2012; Rostosky & Riggle, 2017). In a diverse sample, LGB individuals of color were more likely to affiliate with a non-affirming religious institution, perhaps for a sense of social support and community that is unavailable in affirming religious institutions that are majority white (Barnes & Meyer, 2012). In the example of Lisa and Michelle above, this may explain why Lisa still wishes to attend church even though the church may not be affirming of her relationship.

Affirming faith experiences, however, can support partners' coping efforts and strengthen their bond with each other (Rosenkrantz et al., 2016). Over the life course, a positive religious or spiritual identity can provide support through the developmental transitions of marriage or committed partnership, parenting, caregiving, aging, and death. This seems to be what Lisa is looking for now that she is a parent. Michelle did not have positive experiences with organized religion and is skeptical that it will make a positive contribution to their family.

An affirmative faith may also be a source of comfort and coping, for example during financial or health crises. Navigating common life transitions and crises often prompt couples to seek therapy, as in the case of Lisa and Michelle, so therapists should be prepared to offer culturally attuned services supporting the intersections of sexual identity and religious identity, while also considering the complex influences of age, sex, socioeconomic status, education, race/ethnicity, and geographical location. In working with Lisa and Michelle, the therapist will need to consider the intersections of their sexual orientation/identity, their faith backgrounds (including one partner who has a history of oppression in her faith background), and their racial identities. Addressing these factors allows the therapist to build an effective therapeutic alliance. Later in the chapter, we offer specific ideas and techniques on how to address these and other intersections that uniquely shape a couple's specific situation.

While religion takes many forms that can be either helpful or hurtful to LGB couples, spirituality, which may or may not be expressed through religious belief and practice, addresses the interconnectedness of self, other, and world, and is thus inherently relational (Walsh, 2013). Therefore, regardless of whether the partners have rejected all forms of religion or are working to integrate their sexual and religious identities, positive spirituality can serve as a resource

supporting couple resilience in coping with minority stressors and adversity, and couple relational health and well-being (Rostosky & Riggle, 2015).

A primary goal of this chapter is to provide therapists with some practical tools for conceptualizing, assessing, and facilitating LGB couples' spirituality (i.e., shared values and commitments in response to existential questions) as a resource for coping with stressors, and building and maintaining a positive and supportive relationship. First, we briefly describe minority stress theory as the framework for understanding experiences of religion-based discrimination and stigma that may negatively affect LGB couples' relational functioning. We then offer case examples to illustrate how the spirituality and spiritual values of LGB couples can be used to decrease minority stress and facilitate their relationship goals.

Our thinking is grounded in Mahoney's (2013) framework that assumes spirituality is inherently relational in its process and outcomes. Our recommendations take a strengths-based approach in recognition of the couple-level strengths that have been documented in the research literature on same-sex relationships (see review in Rostosky & Riggle, 2017) and recent evidence that integrating positive religious and/or spiritual identity with a positive sexual identity supports psychological health and well-being (Rodriguez et al., 2019; Rosenkrantz et al., 2016).

Religion-Based Sources of Minority Stress

The use of religious doctrine and authority as a mechanism to maintain the oppression of racial and ethnic minorities and women has a long history**.** Same-sex relationships have been condemned by religious authorities and many LGBTQ people continue to suffer rejection in their religious communities and families. Religious institutions that promote stigma and foster discrimination and prejudice can be a prominent source of minority stress.

Minority stress is the chronic stress that accompanies a stigmatized identity (Brooks, 1981). As applied to LGBTQ individuals, minority stress includes experiences of discrimination and prejudice, anticipation of rejection, concealment or disclosure of the stigmatized identity, the internalization of negative societal views (i.e., internalized stigma), and the efforts expended to cope with these stressors (Meyer, 2003, 2007). Lisa and Michelle are faced with minority stress manifested in a concern that they will be rejected as a couple and family because of their sexual identities. Even thinking about going to a new church creates anxiety and may trigger past issues of hurt and shame. LGB couples experience this and other types of minority stress that impact their daily lives and relationships.

For some (but not all) LGB couples, religious institutions are a source of minority stress to the extent that religion has been used to justify prejudice and discrimination against sexual minorities and their committed partnerships. As in the case of Lisa and Michelle, forming a committed relationship with a lesbian partner and/or becoming parents may represent a developmental milestone that intensifies any conflict between religious identity and sexual identity. Couples who have not previously addressed this conflict may feel uncomfortable doing so, impacting the health of the relationship. In many religion-based institutions, scriptures and doctrines are interpreted in ways that support the condemnation of non-heterosexual identities, the disapproval of non-traditional gender roles/expressions, and the rejection of same-sex couples and their families. Lisa and Michelle have likely experienced this disapproval in overt as well as covert messages from their faith traditions.

Partners who have been raised in a non-affirmative religious context may internalize these negative views and experience shame to the point of hiding their same-sex relationship from religious family members and others in an effort to cope with anticipated rejection. All too commonly, partners from religious families report histories that include pressures to renounce their same-sex attractions under threat of eternal damnation and social isolation from family and community (Barton, 2010; Murr, 2013) and as a result, partners may struggle with guilt, shame,

and high levels of internalized stigma (Barnes & Meyer, 2012; Sherry et al., 2010). High levels of internalized stigma and religious fundamentalism have motivated sexual minorities, especially men and persons of color, to participate in sexual re-orientation therapies (Maccio, 2010), which after extensive review of the scientific evidence the American Psychological Association determined are ineffective and potentially harmful to health and well-being (American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation, 2009).

To reconcile and reclaim their religious/spiritual selves, partners who have suffered as a result of their non-affirming religion-based experiences may need to work through past experiences that have been detrimental to their individual and couple identity. Because Lisa and Michelle have vastly different experiences with religion, spirituality, and acceptance of their sexuality, their therapy sessions will likely first focus on understanding how their past religion-based experiences have shaped their thoughts and feelings as individuals and as a couple.

LGB Couples' Coping with Minority Stress Through Spiritual and Religious Involvements

At present, few research studies are available to inform therapists about the role of religiosity and faith communities in the relationships of LGB couples. While having the same religious affiliation was not related to the relationship satisfaction of female same-sex couples (Smith & Horne, 2008a), other evidence suggests that LGB couples who share similar levels of *intrinsic* religiosity (an internal, guiding framework for their lives) report higher relationship satisfaction (Rostosky, Otis, et al., 2008). In interviews exploring religiosity and spirituality in same-sex couple relationships, both male and female couples asserted that their shared spiritual worldview was an important touchstone or foundation for their relationship (Rostosky, Otis, et al., 2008). In interviews, some midlife same-sex couples perceived that the longevity of the relationship was in part because of their shared religious backgrounds and values (Riggle et al., 2016).

Thus, it may be important to help couples discuss their religious or spiritual similarities and differences and negotiate meaningful religious or spiritual activities that they can share together. In working with Lisa and Michelle, a therapist might help the couple identify their spiritual values, manage any conflict associated with their differences in spiritual values, and facilitate a process of generating creative solutions that meet their family's needs. Consider the following scenario with Lisa and Michelle in a couple's therapy session:

Therapist: Lisa, what beliefs about spirituality do you share with Michelle?

Lisa: Well, clearly, we are both good people and want what is best for our son. I feel like we both are guided by the belief that we should be kind and try to treat other people the way we would like to be treated.

Therapist: It sounds like you both have the same beliefs about how you treat other people. Fundamentally your approach to life is very similar?

Michelle: Yes, I think we are probably more alike than we are different in many ways. I just don't feel we need to be a part of a church to do that.

Therapist: I think I am hearing that on the most important issues, such as your guiding beliefs, you both feel you are on the same page?

Lisa: Yes.

Michelle: Yes.

Therapist: Michelle, since being a part of church does not feel appealing to you right now, can you think of any other activities that you could do as a family that might support the spiritual values that you share?

Michelle: Maybe we could be more intentional about doing service-type activities together, like volunteering at the food pantry. I would love for our son to learn the importance of helping others.

To cope with the minority stress that is generated by religion-based institutions and communities, couples report using several strategies (Rostosky, Otis, et al., 2008). Couples may refuse to participate in institutions that do not support their relationship and thus may reject religion and religious practice (Halkitis et al., 2009; Sherry et al., 2010). Halkitis and colleagues' convenience survey of 498 LGB adults found that only 25% of the sample currently affiliated with a religious institution even though the majority were raised in a Christian or Jewish faith. Participants also reported that they were more spiritual, collectively defined as pursuit of meaning, transcendence, and connection, than religious, which they defined as structured belief systems and organized worship.

Thus, as a second strategy, couples may adopt a subjective and private spirituality. In interviews, couples identified joint activities they consider "spiritual," including prayer and meditation, travel to other countries and cultures, enjoying nature, or reading inspirational texts (Rostosky, Riggle, et al., 2008). Any activity or sphere of life can be infused with spiritual meaning by one or both partners. Couples may, thus, imbue their relationship, parenting, work lives, and/or social activism with transcendent meanings and values. Consider the following example:

> A therapist, while working with a same-sex couple, brought up the topic of emotional connection. She asked Henry and Will to identify how they felt they were able to stay emotionally connected through the years. The couple, together for thirteen years, attribute part of the success of their relationship and emotional connection to activities and projects they do together that they feel link them spiritually. They both are passionate about the environment and volunteer once a month with a local organization that conducts community clean up and recycling activities. Henry was a long-time supporter of the local Humane Society. Will is now also involved and they foster rescue animals when needed. They both discuss how these activities enhance their individual and shared spirituality while connecting them to "the greater good."

Imbuing their relationship with spiritual meaning helps some LGB couples cope with difficulties and challenges brought on by others' religion-based prejudice against them while maintaining a positive focus on the spiritual ideals of authenticity and generosity (Rostosky, Riggle, et al., 2008). Furthermore, spirituality, as a source of connection, purpose, and meaning in life, has been associated with higher levels of sexual satisfaction in same-sex partnered women (Smith & Horne, 2008b). With Lisa and Michelle, a therapist might suggest the couple find a common spiritual activity to share, such as a faith community or a family ritual (for example, walking a labyrinth in the local park each week or reading affirming devotional material together). For some couples, creating special rituals and traditions that have unique spiritual meaning strengthens family identities and relationships, and "touch us at the core of our humanity" (Imber-Black, 2009, p. 230).

Another strategy that LGB couples have used involves rejecting or re-interpreting the religious views of their past, letting go of destructive religion-based beliefs, and adopting new interpretations of sacred texts and new affirmative beliefs (Rostosky, Riggle, et al., 2008). This may be done in the context of working with supportive clergy or through individual reading and reflection. This strategy may allow some couples to continue a meaningful participation together in congregational activities. For these couples, religion and spirituality continued to be a source of support that may counter some of the negative effects of minority stress and enhance relationship satisfaction. In the first case example, Michelle might discover that by being open to Lisa's positive experiences and understanding the value to her partner, she can redefine some of the negative messages of her religious past.

A recent survey of 256 LGBT young adults found that one in four imbued their romantic relationship with sacred meaning and significance, and this "sanctification" of the relationship

was associated with positive relationship qualities such as investment and emotional intimacy (Phillips et al., 2017). Giving one's couple relationship spiritual significance may provide an important coping strategy for dealing with minority stress, difficult life events, and transitions that inevitably occur in long-term relationships.

Likewise, some LGBTQ parents draw on religious and spiritual resources to support them in their parenting. In a qualitative study, 75 LGBTQ parents described their sense of responsibility for teaching their children to critically weigh religious doctrine beliefs and adopt affirmative spiritual values and practices that supported their family and personal growth and development. Parents were also motivated to find spiritual communities supportive of their children's spiritual growth and development and their sense of connection and belonging (Rostosky et al., 2016). In the first case example, Lisa feels that she would like to raise their son in a positive, spiritual community.

For sexual minority individuals, welcoming and affirming congregations, such as the Metropolitan Community Church, the Unitarian Universalist Church, or Earth-spirited religious or spiritual communities (see Smith & Horne, 2007), offer social support and stress-buffering effects that may facilitate the integration of positive sexual and religious identities (Rodriguez, 2010; Rodriguez et al., 2019). These and other affirmative faith-based groups support and validate LGB couples by recognizing couples and families and fully including them in spiritual life and leadership. Experiencing such affirmation in one's faith community has been shown to be related to lower levels of internalized homonegativity in LGB individuals (Lease et al., 2005).

Certainly, much empirical work remains to be done to understand *how* different religious or spiritual involvements and commitments function to either help or hinder LGB couples' relationships. To the extent that it provides social support, a sense of meaning and purpose, coping resources, and positive emotions such as hope and optimism, religion or spirituality may contribute to relationship quality and stability. In conceptualizing and assessing religion and spirituality, therapists should remember that these constructs can be highly related, partially related, or unrelated for any particular couple.

Ethan and Jacob met a year ago at the gay pride parade in Boston. They live together and are planning a wedding ceremony in the next few months. Ethan, who moved to Boston for a job after graduating from the University of Iowa, describes his spiritual beliefs as mostly Buddhist. He regularly attends a mindfulness meditation group and studies and practices Zen principles. He describes his spiritual pursuits as more of a life philosophy than a religion. Jacob grew up in Brooklyn as a Modern Orthodox Jew. When he came out at age 24, he affiliated with Reformed Judaism, a more liberal branch of the religion. He continues to explore this transition and how to interpret and integrate Jewish traditions in his life as a gay man.

The couple has decided to participate in premarital therapy before their upcoming wedding. Both partners feel that it is important to understand each other's spiritual beliefs; however, their interactions seem to become unproductive when Jacob discusses his feeling of oppression associated with being a Jew. Ethan, while intellectually understanding the history of oppression suffered by many Jews, admits that he does not fully understand the intersection of Jacob's faith and his feelings of oppression as a gay man. Ethan offers Jacob some Buddhist ideas about how to use the struggle to learn and grow. Unfortunately, this tends to only cause a further disconnect for the couple.

They discussed talking with a Rabbi, but Ethan says he would feel more comfortable talking with a therapist first. In working with a therapist, the couple will need to address the intersectionality of Jacob's spirituality and his feelings of oppression as a gay man.

Finding common ground for the couple will include moving past simple validation of each other's beliefs toward a deeper understanding of Jacob's struggle with the intersection of religious and sexual identities.

Assessing Religiosity and Spirituality in Couples' Therapy

To be culturally competent, therapists need to be willing and able to help LGB couples attain the highest level of relational functioning and satisfaction. For many couples, this will involve assessing their religious and spiritual values and how they express those in ways that are affirming to their relationship. Pargament and Krumrei (2009) recommend a comprehensive approach to spiritual assessment, including assessing: (a) the place of spirituality in the clients' lives (central to peripheral); (b) the location of the clients in their individual spiritual journeys (engaged, disengaged, conserving or transforming, stuck or struggling); (c) the content of the client's spirituality and how it is expressed; (d) the context of the clients' spirituality; (e) the impact (on health and well-being) of the clients' spirituality; and (f) the appropriate place of spirituality in the clients' treatment.

A brief spiritual assessment allows the therapist to determine what role religion and spirituality plays for each partner and if spirituality issues are perceived to be connected to the presenting issue (Koenig, 2013). In the case of Ethan and Jacob, sharing and understanding their religious and spiritual values is a primary motive for seeking therapy. For the therapist, the assessment is not so much an exploration into the couple's theology or worldviews, but rather a way to gain an understanding of how spirituality and religion-based beliefs impact the couple's relationship and their life together. The overarching assessment task is to explore ways that religion or spirituality may have contributed to the couple's distress as well as the ways that spiritual resources may be drawn upon to increase well-being (Walsh, 2009). Examples of a brief spiritual assessment might include the questions below, which were adapted from Hodge (2005) and Sperry (2001):

- How does religion and/or spirituality play a part in your life as an individual and as a couple?
- How does your spirituality help you in your life?
- What challenges does your spirituality pose in your life?
- Do you and/or your partner attend a church, synagogue, temple, sangha, or other type of spiritual community? Do you attend together or separately?
- Do you (occasionally or regularly) engage in any spiritual activities?
- Do you feel you and your partner have similar views on religion and spirituality?
- Would you like to address your religious or spiritual beliefs and practices in our sessions?

These types of questions will help the therapist to understand if religion or spirituality is an area that is pertinent to the presenting issue(s). Because some therapists prefer to do individual assessments with each partner, the questions are formatted so they can be asked individually or to the couple. If the results of the brief spiritual assessment suggest that religion and/or spirituality are salient issues for the couple, or is an area of conflict, then a full spiritual assessment could be performed in following sessions. A full assessment might include taking a spiritual history from the couple, either individually or together. Below are suggested prompts for taking a spiritual history, adapted from Hodge (2005) and Sperry (2001):

- Describe the religious/spiritual tradition in which you were raised.
- How did your parents and their families express spiritual beliefs?
- How important was religion or spirituality to your family?

- Did your parents share the same religion/spirituality? If not, how did they negotiate differences in their beliefs?
- What were some of their most important spiritual beliefs? Did they pass these on to you?
- Do you recall any significant experiences (either positive or negative) while growing up that had to do with religion or spirituality?
- Have religious or spiritual issues caused any problems between you and your family?
- Has or does your sexual orientation affect your spiritual or religious beliefs? How?
- Is your current spiritual orientation different from your family of origin? How? Does this cause any kind of problems or distress for you or your family?
- If you have children, do you and your partner agree or disagree on the spiritual orientation with which they are being raised?

For LGB couples, a full spiritual assessment includes asking couples how their religious or spiritual identities have been influenced by other important aspects of their identities (e.g., gender, race, ethnicity, national origin, ability, sexual orientation, class). As previously noted, this may be of particular importance for LGB individuals dealing with minority stress amplified by other aspects of their lives that may also be stressful. To assess for the impact of intersectional identities, the therapist might ask some of the following questions:

- How does identifying as gay (or other sexual identity) and a cisgender woman (or other gender identity) impact your personal spirituality or religious beliefs?
- How does your race (or ethnicity) along with your sexual orientation (or identity) affect your spiritual or religious beliefs in unique ways?
- In addition to your sexual identity and race/ethnicity, how have *other* aspects of your background and culture influenced your spiritual or religious beliefs?

For partners who indicate they are involved or committed to a particular theistic religious tradition, it is also important to ask how their religious beliefs support their lives. Partners should be asked to provide the therapist with the appropriate term(s) for addressing their theological beliefs (e.g., God, Goddess, Higher Power, Life Force, or any other label supplied by the couple). These beliefs can be an important resource for coping with the stress and challenges of life. Some important assessment questions in this area may include:

- How do you understand your place in or relationship to the world/universe?
- What religion-based or spirituality-based beliefs and practices do you draw on in times of stress or challenge?

Hodge (2013) identifies other assessment tools available for a more comprehensive assessment. These include spiritual and religious life maps, spiritual genograms, and spiritual and religious eco maps. These tools may be helpful in assessing partners' religious legacy and spiritual evolution across time. In his article on spiritual assessment with couples, Hodge lists quantitative inventories of spiritual development and spiritual well-being, and demonstrates ways to use these tools (Hodge, 2013). Walsh (2009) suggests that therapists assess possible spiritual resources and practices, including personal faith, contemplative practices, connection with the faith community, creative arts expression and appreciation, connection to nature, service to others, and activism.

Including a spiritual assessment in a holistic bio-psycho-social-spiritual assessment model will help therapists touch on all domains that intersect and are likely relevant to therapy. This holistic approach will help the therapist understand each partner's individual spiritual orientation and how these values have shaped that person's life experiences. Also of primary importance

is understanding the extent to which spiritual and religious issues have resulted in perceived connection or disconnection in the couple relationship. As noted by Rostosky, Riggle, and colleagues (2008), spirituality and religiosity can be a source of strength and support in LGB relationships. Or, like other issues, it can be an area of disconnection, resentment, and confusion. An in-depth understanding of how spirituality and religion impact each individual and the relationship will hopefully increase awareness within the couple and help them begin to generate goals and build solutions supporting their relationship. For Ethan and Jacob, interventions that increase their ability to communicate their thoughts, feelings, beliefs, and needs with each other would be particularly important. While they have taken different spiritual paths up to this point, helping them find common elements and possible areas of concern would likely help them build intimacy and connection as a couple.

Therapeutic Interventions with LGB Couples

Although therapists generally acknowledge the importance of assessing the spiritual backgrounds and values of their clients, according to their own reports, they are "reluctant to act" on this assessment information (Frazier & Hansen, 2009, p. 85). This reluctance may be due to a lack of training in appropriate and effective interventions (Frazier & Hansen, 2009; Post & Wade, 2009). Once therapists have assessed the degree to which each partner's religion-based backgrounds and current religious or spiritual activities are sources of support or sources of minority stress, the next step is to collaborate with the couple on strategies for addressing any aspects of minority stress that are exacerbated by experiences with religion-based institutions, family members, or others who convey non-affirmative religion-based attitudes. This may be ascertained as part of the initial assessment or may be something that becomes more tangible in later sessions through gentle probing. In a brief report on clinical practice, Plante (2016) identified six principles for incorporating spirituality into clinical practice:

- Treat spirituality and religion as a multicultural and diversity issue.
- Keep biases in check.
- Stay within one's area of expertise.
- Refer to experts including clerics or spiritual practitioners.
- Be aware of best practices and evidence-based assessments and interventions.
- Use resources where available.

As the working phase of therapy commences, clients may "test the waters" to see if a therapist will be sensitive and respectful before disclosing their religion-based or spiritual concerns. This initial reticence on the part of clients may partially explain why these issues are more likely to emerge gradually over the course of therapy (Post & Wade, 2009). In the case of Ethan and Jacob, early therapy sessions should focus on creating a safe therapeutic alliance where each partner can explore and understand his own and his partner's religion-based experiences, spiritual values and meanings, and how differences are impacting their relationship. It is important for the therapist to be particularly sensitive to how Ethan and Jacob experience the intersectionality of being an LGB couple as well as belonging to different religious communities. The therapist will need to work on multiple levels to help the couple feel safe and to build a strong therapeutic alliance.

With very few role models or "scripts" to follow, LGB couples are often left on their own to figure out how to deal with religion-based or spiritual issues that might arise in their relationship. As new parents, Lisa and Michelle's concerns about child-rearing, spiritual communities, and combining spiritual beliefs and practices with family traditions have generated internal and interpersonal conflict. When an LGB couple presents for couples' therapy with these types of concerns, therapists should be prepared and comfortable in offering non-judgmental,

therapeutic guidance and support as couples develop and move along their unique paths to health and well-being.

In working with the couples in the previous case examples, therapists should help their clients discover the *meaning* of religion and spirituality in their lives as it intersects with other social identities such as race, gender, and class. Assessing and addressing how religion-based institutions and beliefs have contributed to minority stress in the couple's lives helps to externalize the problem so that Lisa and Michelle, and Ethan and Jacob are not caught up in blaming themselves or each other for difficulties. The therapist can serve as an effective "witness" to any discrimination or rejection the couple may have experienced in the past or anticipate experiencing in a religious setting. By offering this validation, the therapist strengthens the therapeutic relationship and empowers the couple to move away from past negative experiences toward new, affirmative opportunities.

Therapists can also help couples identify any negative impacts of religion-based prejudice that may be internalized. To identify internalized negative beliefs about their sexual identities or LGB couple relationship, therapists can assign journaling exercises or thought-monitoring tasks. Interventions to replace negative beliefs with more self-accepting and affirming beliefs may include spiritually based interventions such as lovingkindness and other mindfulness meditations. In general, research is demonstrating the power of positive emotions in health and well-being; thus, interventions to increase positive emotions such as love, hope, forgiveness, and acceptance should be part of couples' therapy (Fredrickson, 2003).

Drawing on the basic principles of Emotionally Focused Therapy (Greenberg & Johnson, 1988), therapists can help the couple see where they are becoming disconnected and then facilitate new connections as their awareness increases about the meaning of religion or spirituality in each of their lives. Positive relational practices can be assigned as homework to encourage couples to deepen their sense of spiritual and emotional connection. For instance, couples might develop letter writing rituals that express appreciation and gratitude toward each other. They can be encouraged to share positive narratives about how they met and times they felt lucky or blessed to be together. Drawing on the positive aspects of their relationship and connection can strengthen their relational bond.

Since minority stress is a chronic form of stress that can negatively impact couple relationships, therapists can suggest couples engage in mindfulness meditation, yoga, prayer, or other forms of meditation to help them cope. To help couples explore the meaning of spirituality in their lives, the therapist may wish to incorporate exercises for the couple to do at home. LGB couples might benefit from writing and sharing their spiritual autobiographies, creating and using rituals that celebrate the uniqueness and significance of their relationship, or jointly completing a spiritual needs and resources inventory (Serlin, 2005). Couples' strengths and resources can be marshaled by using a discovery-oriented, collaborative approach honoring their specific spiritual values and resources. Spiritual resources can be found in nature, in music, and in social activism as well as in religious or spiritual communities and traditions (Walsh, 2009).

Transcendent values of compassion, generosity, and forgiveness may also be practiced and reinforced as couples participate in the process of identifying and negotiating solutions to any internal and external sources of minority stress causing them distress. Helping couples create meaning and construct spiritual support systems can help couples develop psychological maturity (Serlin, 2005) and enhance well-being. Therefore, therapists need to be aware of affirmative spiritual resources for LGB couples and their families.

Training Therapists to Be Effective with LGB Couples' Religious/Spiritual Issues

The fields of psychology, family therapy, and social work avoided spirituality and religion in clinical training until recently (Walsh, 2009). Believing that therapists might somehow offend

clients or unprofessionally share their bias with clients, most training programs instructed their students to tread lightly in this domain. While that has changed in the last few years, there is still little empirical research and clinical training available for working with LGB couples in the area of religion and spirituality.

Establishing a Therapeutic Alliance

Therapists in training must be effective in establishing a strong therapeutic alliance with LGB couples as this has been shown to predict positive outcomes in adult psychotherapy (Friedlander et al., 2018; Lambert & Barley, 2001). Engaging the partners so they feel equally heard and understood by the therapist should be the first priority in the therapeutic process. Findings from a qualitative study of same-sex couples suggest that respondents are concerned about their therapist's knowledge about and comfort level with their identities; in addition, same-sex couples are concerned when they suspect that a therapist may be overcompensating for negative attitudes toward them as a couple (Grove & Blasby, 2009). Problematic therapist behaviors include being overly tentative, overly cautious, or avoidant of exploring or challenging possible negative aspects of the couple relationship. In the following example, the therapist is being over-cautious:

> The therapist is meeting with Thad and Calvin for their first couple's therapy session. As he inquires about their histories, there is some information with which he appears to be uncomfortable:

Therapist: Thad, you were telling me about your life before you met Calvin. Could you tell me some more about it?

Thad: Well, before I met Calvin, I was involved with a group of guys that liked to party together. We would travel together to different circuit events and often engage in group sex activities.

Calvin: I was never involved with anything like that and don't really understand how you could just have sex with different people. I'm trying really hard to trust Thad, but sometimes I feel weird that he has had sex with so many different people in the past. My religious belief is that couples should be monogamous. I believe God wants us to be faithful to each other. I know that was in the past, but I still feel funny about it at times.

Therapist: Well, since that was in the past, perhaps it would be best for us to focus on your relationship now and how to make things better in the future.

In this example, the therapist may be uncomfortable discussing either sexuality or spirituality (or both). This discomfort may lead him to move away from Thad's disclosure, even though Calvin is obviously troubled by it and expresses a desire to work through some of his feelings about it. This avoidance on the therapist's part could be damaging to his therapeutic alliance with the couple. Hopwood and Witten (2017) note that it is imperative for therapists to have self-awareness concerning their possible biases and personal religious or spiritual beliefs so they do not interfere with the therapeutic process.

A strong therapeutic alliance characterized by caring, trust, open-mindedness, and hope will facilitate couples' comfort with sharing potentially emotionally laden information about the intersection of sexual orientation, spirituality, and religion. The couple needs to feel that the therapist truly understands their situation and past struggles. They should also feel assured that the therapist is non-judgmental, agenda-free, and unconditionally supportive of both partners (Burckell & Goldfried, 2006; Hopwood & Witten, 2017; Plante, 2016). Moreover, much has been written about building a therapeutic relationship with individuals and couples. The therapist can take certain steps to indicate that they are affirming of LGB couples. Therapists should, for example, provide LGBT-related reading materials in their waiting room and routinely use inclusive language that does not make heterosexist assumptions.

Competence in Addressing Spirituality and Religion

In addition to developing competence related to LGB relationship issues, therapists should develop competence in the spiritual and religious issues that couples encounter. A recent review of religion/spirituality in therapy concluded that one of the most important things therapists can do is make an explicit statement at the beginning of therapy communicating openness to discussing religious/spiritual issues (Koenig, 2013; Post & Wade, 2009). For example, the therapist might say,

> Although it is not my role to provide spiritual or religious direction or advice to you, I am comfortable discussing your spiritual beliefs and concerns in our sessions. For many people, aspects of their spiritual and religious life are important parts of their identities, so I want you to know I welcome the opportunity to help you explore *all* parts of your identity in our work together.

Unfortunately, many therapists feel uncomfortable discussing religion or spirituality in sessions (Duba & Watts, 2009). Some feel they are not qualified to discuss spiritual concerns with individuals or couples and thus avoid the topic. However, some therapists (e.g., Sperry, 2001) who draw upon the importance of the self of the therapist consider the therapist's own spiritual journey to be vital to the interpersonal process of guiding others. From this perspective, therapists should have first-hand experience with finding spiritual meaning in their own lives before they assist others.

If the therapist has a strong bias against organized religion or disregards spirituality as important in working with clients, the therapist should seek supervision or individual therapy to resolve these issues so they do not interfere with treatment. As with other aspects of diversity, therapists should examine their own religious beliefs or negative attitudes toward religion to ensure that their personal biases do not interfere with an ability to understand, respect, and effectively treat diverse clients (Plante, 2016). One suggested intervention for helping therapists in training become aware of their own beliefs and biases in the area of religion and spirituality is to write their own spiritual autobiography (Koenig, 2013) and explore the assumptions they make based on their beliefs and backgrounds.

The Role of the Therapist

Therapists do not have to share the same sexual identity or sexual orientation of their clients. A study of bisexual and lesbian women found that the competence of the therapist was more important than the sexual orientation of the therapist (Burckell & Goldfried, 2006). Therapists must, however, have a frame of reference to be able to convey genuine empathy (Bowland et al., 2013).

Therapists who are religious should be aware that because of possible negative experiences with religion in the past, some LGB couples may make very negative comments about religion, the church, and those who attend church. The therapist must be able to remain empathic with these emotions and perceptions (Bowland et al., 2013). Therapists and trainees should ensure that they are familiar with religious and spiritual resources in their local communities and on the internet. Some useful resources are included in Table 19.1. It is recommended that therapists familiarize themselves with the scriptures, rituals, traditions, and spiritual reading materials that the clients mention in therapy (Sperry, 2016).

Another training issue is appropriate self-disclosure. A couple in therapy may be curious about the spiritual beliefs of the therapist. As with any personal self-disclosure, the therapist must determine if sharing personal information is in the best interest of the client or couple. If sharing personal information will inhibit the therapeutic process by making the couple feel uncomfortable in sharing spiritual information because they feel it to be incongruent with the therapist's personal beliefs, then the therapist would be advised not to disclose too much

Table 19.1 Resources

Affirmative Religious Organizations	
Affirmation- United Methodist for Lesbian, Gay, Bisexual and Transgender Concerns (www.umaffirm.org)	Integrity (Episcopalian) (www.integrityusa.org)
Al Fatiha (Islam) (www.al-fatiha.org)	Lutherans Concerned/North America (www.lcna.org)
Association of Welcoming and Affirming Baptists (www.wabaptists.org)	Metropolitan Community Church (www.mccchurch.org)
Dignity/USA (Catholic) (www.dignityusa.org)	More Light Presbyterians (www.mlp.org)
Friends for Lesbian, Gay, Bisexual, Transgender, and Queer Concerns (Quaker) (www.flgbtqc.quaker.org)	The UCC Coalition for LGBT Concerns (United Church of Christ) (www.ucccolition.org)
The Gay and Lesbian Vaishnava Association (Hindu) (http://www.galva108.org)	QueerDharma (Buddhist) (www.queerdharma.org)
GLAD Alliance (Disciples of Christ) (www.gladalliance.org)	The World Congress of Gay, Lesbian, Bisexual and Transgender Jews (www.glbtjews.org)
Additional Resources	
Human Rights Campaign: Faith and Religion (http://www.hrc.org/issues/religion/religion_introduction.asp)	National Gay and Lesbian taskforce: Faith (www.thetaskforce.org/issues/faith)
Documentaries	
For the Bible Tells Me So (2007) (http://firstrunfeatures.com/forthebibletellsmesodvd.html)	Trembling Before g_d (2001) (http://www.filmsthatchangetheworld.com/site/)
Fish Out of Water (2009) (http://www.fishoutofwaterfilm.com)	A Jihad for Love (2007) (http://firstrunfeatures.com/jihadforlovedvd.html)
For They Know Not What They Do (2019) (https://www.fortheyknow.org/)	

information. The therapist should be sensitive, however, that by withholding information from the couple, the couple may sense reticence and become distrustful of the therapist. However, briefly sharing one's common struggles and faith journey may foster an environment of openness and understanding and may improve the therapeutic alliance by normalizing aspects of the couple's experience, ultimately improving the odds of a positive therapeutic outcome. In the following example, the therapist offers appropriate self-disclosure to help reassure a couple and normalize their struggle:

Donna and Charice: We feel that we would like to be involved in a church, but not a church like the ones we grew up in that are not welcoming of LGBT folx. We miss going to church, but are not sure it is even worth the effort to try and find a welcoming congregation.

Therapist: I have worked with several couples that have had similar struggles with wanting to be involved with a congregation but felt tentative about visiting churches. When I first moved to the area several years ago, I remember struggling with this issue as well, since my husband and I wanted to attend a church that was welcoming and affirming of all people. We looked online at several churches and decided to visit a few. I remember how awkward it was to visit and wondered if it was worth the effort. I remember feeling a little intimidated at times. We can certainly talk more about your feelings about exploring churches if you feel that would be helpful.

Trainees need to learn how the interpersonal process of discussing emotional and possibly sensitive topics such as spirituality and sexuality may trigger feelings in the client that are projected

onto the therapist (transference) and, alternately, may trigger feelings in the therapist that interfere with effective therapeutic responding (countertransference). For example, if one member of the couple becomes defensive when describing their faith background or beliefs, they may project onto the therapist (and their partner) ridicule or abuse they have experienced in the past. Likewise, when one of the clients unknowingly berates the therapist's religious tradition or faith, this might cause the therapist to respond defensively by inappropriately challenging the client. If the couple and therapist share the same religious beliefs, there might be personal differences in how each approaches specific issues. Assumptions and differing expectations may lead to conflicts within the therapy sessions, and therapists must learn how to address these conflicts and use them as part of an effective therapeutic process.

Conclusion

At its best, the process of therapy may be "a spiritual well-spring for healing and resilience" (Walsh, 2009, p. 51) as LGB couples rise to meet the challenges they face and forge lives of meaning, connection, and purpose. LGB couples can draw on spirituality and spiritual resources to support the health and happiness of their relationship and their individual sense of wholeness and belonging. A spirituality-based relationship can help couples join together in practicing compassion for each other, for their communities, and for the world. This can be healing for those whose lives and identities are stigmatized. Thus, the couple relationship can be a safe haven for cultivating empowering love, spiritual growth, and self-transcendence. Therapists can help couples in this endeavor by addressing religion-based experiences of minority stress and facilitating the positive spiritual values and meanings that serve as resources as they confront the challenges of life. Understanding the social context of LGB couples' lives, which includes their religious and spiritual backgrounds and values, supports and encourages their health and well-being.

References

American Psychological Association Task Force on Appropriate Therapeutic Responses to Sexual Orientation. (2009). *Report of the American Psychological Association Task Force on appropriate therapeutic responses to sexual orientation*. https://www.apa.org/pi/lgbt/resources/sexual-orientation

Barnes, D. M., & Meyer, I. H. (2012). Religious affiliation, internalized homophobia, and mental health in lesbians, gay men, and bisexuals. *American Journal of Orthopsychiatry, 82*(4), 505–515. https://doi.org/10.1111/j.1939-0025.2012.01185.x

Barton, B. (2010). "Abomination"—Life as a bible belt gay. *Journal of Homosexuality, 57*(4), 465–484. https://doi.org/10.1080/00918361003608558

Bowland, S. E., Foster, K., & Vosler, A. N. R. (2013). Culturally competent and spiritually sensitive therapy with lesbian and gay Christians. *Social Work, 58*(4), 321–332. https://doi.org/10.1093/sw/swt037

Brennan-Ing, M., Seidel, L., Larson, B., & Karpiak, S. E. (2013). 'I'm created in God's image, and god don't create junk': Religious participation and support among older GLBT adults. *Journal of Religion, Spirituality & Aging, 25*(2), 70–92. https://doi.org/10.1080/15528030.2013.746629

Brooks, V. R. (1981). *Minority stress and lesbian women*. Lexington Books.

Burckell, L. A., & Goldfried, M. R. (2006). Therapist qualities preferred by sexual-minority individuals. *Psychotherapy: Theory, Research, Practice, Training, 43*(1), 32–49. https://doi.org/10.1037/0033-3204.43.1.32

Duba, J. D., & Watts, R. E. (2009). Therapy with religious couples. *Journal of Clinical Psychology, 65*(2), 210–223. https://doi.org/10.1002/jclp.20567

Frazier, R. E., & Hansen, N. D. (2009). Religious/spiritual psychotherapy behaviors: Do we do what we believe to be important? *Professional Psychology, Research, and Practice, 40*(1), 81–87. https://doi.org/10.1037/a0011671

Fredrickson, B. (2003). The value of positive emotions. *American Scientist, 91*(4), 330–335. https://doi.org/10.1511/2003.4.330

Friedlander, M. L., Escudero, V., Welmers-van de Poll, M. J., & Heatherington, L. (2018). Meta-analysis of the alliance-outcome relation in couple and family therapy. *Psychotherapy, 55*(4), 356–371. https://doi.org/10.1037/pst0000161

Greenberg, L. S., & Johnson, S. M. (1988). *Emotionally focused therapy for couples.* Guilford.

Grove, J., & Blasby, S. (2009). The therapeutic encounter in same-sex couple counselling – The client's perspective. *Counseling and Psychotherapy Research, 9*(4), 257–265. https://doi.org/10.1080/14733140903012903

Halkitis, P. N., Mattis, J. S., Sahadath, J. K., Massie, D., Ladyzhenskaya, L., Pitrelli, K., Bonacci, M., & Cowie, S. E. (2009). The meanings and manifestations of religion and spirituality among lesbian, gay, bisexual, and transgender adults. *Journal of Adult Development, 16*(4), 250–262. https://doi.org/10.1007/s10804-009-9071-1

Hodge, D. (2005). Spiritual assessment in marital and family therapy: A methodological framework for selecting from among six qualitative assessment tools. *Journal of Marital and Family Therapy, 31*(4), 341–356. https://doi.org/10.1111/j.1752-0606.2005.tb01575.x

Hodge, D. (2013). The role of religion and spirituality in positive psychology interventions. In K. Parganent, A. Mahoney, & E. Shafranske (Eds.), *APA handbook of psychology, religion, and spirituality: An applied psychology of religion and spirituality* (Vol. 2, pp. 93–123). American Psychological Association.

Hopwood, R. D., & Witten, T. M. (2017). Spirituality, faith, and religion the TGNC experience. In A. Singh & L. Dickey (Eds.) *Psychological practice with transgender and gender nonconforming clients* (pp. 213–230). American Psychological Association. https://doi.org/10.1037/14957-011

Imber-Black, E. (2009). Rituals and spirituality in family therapy. In F. Walsh (Ed.), *Spiritual resources in family therapy* (pp. 229–246). Guilford.

Koenig, H. (2013). *Spirituality in patient care: Why, how, when, and what* (3rd ed.). Templeton Press.

Koenig, H. G., King, D. E., & Carson, V. B. (2012). *Handbook of religion and health* (2nd ed.). Oxford University Press.

Lambert, M. J., & Barley, D. E. (2001). Research summary on the therapeutic relationship and psychotherapy outcome. *Psychotherapy: Theory, Research, Practice, Training, 38*(4), 357–361. https://doi.org/10.1037/0033-3204.38.4.357

Lease, S. H., Horne, S. G., & Noffsinger-Frazier, N. (2005). Affirming faith experiences and psychological health for Caucasian lesbian, gay, and bisexual individuals. *Journal of Counseling Psychology, 52*(3), 378–388. https://doi.org/10.1037/0022-0167.52.3.378

Maccio, E. M. (2010). Influence of family, religion, and social conformity on client participation in sexual reorientation therapy. *Journal of Homosexuality, 57*(3), 441–458. https://doi.org/10.1080/00918360903543196

Mahoney, A. (2013). The spirituality of us: Relational spirituality in the context of family relationships. In K. I. Pargament, J. J. Exline, & J. W. Jones (Eds.), APA handbook of psychology, religion, and spirituality: Context, theory, and research (Vol 1., pp. 365–389). American Psychological Association. https://doi.org/10.1037/14045-020

Mahoney, A., & Krumrei, E. J. (2012). Questions left unaddressed by religious familism: Is spirituality relevant to nontraditional families? In L. J. Miller (Ed.), *The Oxford handbook of psychology and spirituality* (pp. 165–181). Oxford University Press. https://doi.org/10.1093/oxfordhb/9780199729920.013.0011

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129*(5), 674–697. https://doi.org/10.1037/0033-2909.129.5.674

Meyer, I. H. (2007). Prejudice and discrimination as social stressors. In I. H. Meyer & M. E. Northridge (Eds.), *The health of sexual minorities: Public health perspectives in lesbian, gay, bisexual and transgender populations* (pp. 242–267). Springer. https://doi.org/10.1007/978-0-387-31334-4_10

Murr, R. (2013). 'I became proud of being gay and proud of being Christian': The spiritual journeys of queer Christian women. *Journal of Religion & Spirituality in Social Work: Social Thought, 32*(4), 349–372. https://doi.org/10.1080/15426432.2013.839241

Pargament, K. I., & Krumrei, E. J. (2009). Clinical assessment of clients' spirituality. In J. D. Aten & M. M. Leach (Eds.), *Spirituality and the therapeutic process: A comprehensive resource from intake to termination* (pp. 93–119). American Psychological Association. https://doi.org/10.1037/11853-005

Pew Research Center. (2015, May 12). *America's changing religious landscape*. https://www.pewforum.org/2015/05/12/americas-changing-religious-landscape

Phillips, R. E., III, Kalp, D., Lucci, M., Maccarelli, A., Avant, S., Cenkner, D., & Herndon, R. (2017). Initial validation of measures of sanctification in same-sex romantic relationships and sexual behavior. *Journal for the Scientific Study of Religion, 56*(4), 836–851. https://doi.org/10.1111/jssr.12488

Plante, T. G. (2016). Principles of incorporating spirituality into professional clinical practice. *Practice Innovations, 1*(4), 276–281. https://doi.org/10.1037/pri0000030

Post, B. C., & Wade, N. G. (2009). Religion and spirituality in psychotherapy: A practice-friendly review of research. *Journal of Clinical Psychology, 65*(2), 131–146. https://doi.org/10.1002/jclp.20563

Riggle, E. D. B., Rothblum, E. D., Rostosky, S. S., Clark, J. B., & Balsam, K. F. (2016). "The secret of our success": Long-term same-sex couples' perceptions of their relationship longevity. *Journal of GLBT Family Studies, 12*(4), 319–334. https://doi.org/10.1080/1550428X.2015.1095668

Rodriguez, E. M. (2010). At the intersection of church and gay: A review of the psychological research on gay and lesbian Christians. *Journal of Homosexuality, 57*(1), 5–38. https://doi.org/10.1080/00918360903445806

Rodriguez, E. M., Etengoff, C., & Vaughan, M. D. (2019). A quantitative examination of identity integration in gay, lesbian, and bisexual people of faith. *Journal of Homosexuality, 66*(1), 77–99. https://doi.org/10.1080/00918369.2017.1395259

Rosenkrantz, D. E., Rostosky, S. S., Riggle, E. D. B., & Cook, J. R. (2016). The positive aspects of intersecting religious/spiritual and LGBTQ identities. *Spirituality in Clinical Practice, 3*(2), 127–138. https://doi.org/10.1037/scp0000095

Rostosky, S. S., Abreu, R. L., Mahoney, A., & Riggle, E. D. B. (2016). A qualitative study of parenting and religiosity/spirituality in LBGTQ families. *Psychology of Religion and Spirituality, 9*(4), 437–445. https://doi.org/10.1037/rel0000077

Rostosky, S. S., Otis, M. D., Riggle, E. D. B., Kelly, S., & Brodnicki, C. (2008). Religiosity and same-sex couple relationships. *Journal of GLBT Family Studies, 4*(1), 17–36. https://doi.org/10.1080/15504280802084407

Rostosky, S. S. & Riggle, E. D. B. (2015). *Happy together: Thriving as a same-sex couple in your family, workplace, and community*. American Psychological Association. https://doi.org/10.1037/14620-000

Rostosky, S. S., & Riggle, E. D. B. (2017). Same-sex couple relationship strengths: A review and synthesis of the empirical literature (2000–2016). *Psychology of Sexual Orientation and Gender Diversity, 4*(1), 1–13. https://doi.org/10.1037/sgd0000216

Rostosky, S. S., Riggle, E. D. B., Brodnicki, C., & Olson, A. (2008). An exploration of lived religion in same-sex couple relationships. *Family Process, 47*(3), 389–403. https://doi.org/10.1111/j.1545-5300.2008.00260.x

Serlin, I. (2005). Religious and spiritual issues in couples therapy. In M. Harway (Ed.), *Handbook of couples therapy* (pp. 352–369). Wiley.

Sherry, A., Adleman, A., Whilde, M. R., & Quick, D. (2010). Competing selves, Negotiating the intersection of spiritual and sexual identities. *Professional Psychology: Research and Practice, 41*(2), 112–119. https://doi.org/10.1037/a0017471

Smith, B., & Horne, S. (2007). Gay, lesbian, bisexual and transgendered (GLBT) experiences with earth-spirited faith. *Journal of Homosexuality*, *52*(3–4), 235–248. https://doi.org/10.1300/J082v52n03_11

Smith, B., & Horne, S. (2008a). The role of faith affiliation for women in same-sex relationships. *Journal of GLBT Family Studies, 4*(2), 165–179. https://doi.org/10.1080/15504280802096807

Smith, B. L., & Horne, S. G. (2008b). What's faith got to do with it? The role of spirituality and religion in lesbian and bisexual women's sexual satisfaction. *Women & Therapy, 31*(1), 73–87. https://doi.org/10.1300/02703140802145243

Sperry, L. (2001). *Spirituality in clinical practice: Incorporating the spiritual dimension in psychotherapy and counseling*. Philadelphia, PA: Brunner-Routledge.

Sperry, L. (2016). Varieties of religious and spiritual treatment: Spirituality oriented psychotherapy and beyond. *Spirituality in Clinical Practice, 3*(1), 1–4. https://doi.org/10.1037/scp0000097

Walsh, F. (2009). Integrating spirituality in family therapy: Wellsprings for health, healing, and resilience. In F. Walsh (Ed.), *Spiritual resources in family therapy* (2nd ed., pp. 31–61). Guilford.

Walsh, F. (2013). Religion and spirituality: A family systems perspective in clinical practice. In. K. I. Pargament (Ed.), *APA handbook of psychology, religion, and spirituality: An applied psychology of religion and spirituality* (Vol. 2, pp. 189–205). American Psychological Association. https://doi.org/10.1037/14046-009

20
Treatment of Partner Violence in Sexual and Gender Minority Couples

NATHAN MATHER, DEANNA LINVILLE, and TIFFANY B. BROWN

Introduction

In the past decade, partner violence among sexual minority couples has received more scholarly attention, but gaps in our understanding of the needs of and health disparities for this population persist (Rollè et al., 2018). Partner violence in gender minority couples has been far less studied, despite the high prevalence of victimization for this population, within a society that continues to stigmatize transgender people (Yerke & DeFeo, 2016). *Intimate partner violence* (IPV) refers to a pattern of coercive control consisting of physical, sexual, or psychological acts of aggression committed by a current or former partner (Saltzman et al., 2002; Trabold et al., 2018). Other forms of IPV include economic and spiritual abuse (Browne et al., 1999; Chronister & McWhirter, 2003; Kanuha, 1994), as well as cyber aggression, an emerging form of partner violence characterized by harassing an intimate partner via online platforms and online obsessive relational intrusion (Marganski & Melander, 2018). IPV occurs among different-sex and same-sex couples, as well as among cisgender and transgender couples. We use the phrases *sexual and gender minority IPV* and *queer partner violence* interchangeably to describe violence in the context of couples in which one or both partners identify as a sexual and/or gender minority. We recognize that sexual and gender minority couples are distinct populations, which sometimes overlap, as gender identity and sexual orientation are separate but related identities.

Although we focus our attention on how sexual and gender minority identities relate to experiences of IPV, we emphasize that queer clients often hold additional marginalized identities that make them more vulnerable when seeking treatment. We recommend that clinicians approach each client with cultural humility (Hook et al., 2013), seeking to understand how intersecting identities affect each client's experience of IPV. Numerous studies have examined IPV among queer racial/ethnic minorities, including Black or African American lesbians (Hill et al., 2012) and men who have sex with men (MSM; Beymer et al., 2017; Tran et al., 2014; Williams et al., 2015), Latino gay and bisexual men (Feldman et al., 2007), queer Latinas (Steele et al., 2017), and Asian and Pacific Islander queer women (Kanuha, 2013). King et al. (2019) explored racial/ethnic differences in IPV victimization in a sample of 24,000 transgender people. Collectively, these studies demonstrate that IPV is a salient clinical issue for racial/ethnic minority populations and underscore the importance of acknowledging the roles that cultural factors play in perceptions of IPV, access to services, and related health outcomes, such as HIV risk behaviors.

IPV can also occur within the context of polyamorous, open, and other relationship configurations involving more than two partners (Barrett & Sheridan, 2017), a consideration that warrants attention in future studies and in clinical settings. We encourage clinicians to attend to specific, intersecting identities when treating IPV in sexual and gender minority couples by utilizing Hays' (2001) framework, and we invite researchers to continue to develop empirically

DOI: 10.4324/9780429274626-25

based, affirmative, and culturally inclusive assessments, treatments, and preventive interventions for the diverse sexual and gender minority populations who experience IPV.

Existing literature on queer partner violence tends to focus on four main areas: (a) estimates of prevalence rates of violence in queer populations; (b) examination of IPV correlates and risk factors specific to distinct queer populations; (c) description of the sociocultural forces that influence queer IPV; and (d) identification of barriers queer individuals and couples face in accessing support services, and recommendations for services (Barrett & Sheridan, 2017; Rollè et al., 2018). Likewise, in this chapter, we provide an overview of the current literature on IPV in adult sexual and gender minority relationships regarding prevalence rates, risk factors and antecedents, barriers to accessing services, the sociopolitical context, and protective factors. In addition, we provide clinical recommendations for assessment and treatment specific to queer couples. Finally, we identify specific areas that warrant future study.

Critical Review of the Literature

Several authors have published reviews of sexual and gender minority IPV in the past decade. These reviews have focused on varied topics, including partner violence in transgender populations and recommendations for moving beyond a gender binary in IPV research (Yerke & DeFeo, 2016), partner violence among self-identified lesbians (Badenes-Ribera et al., 2016), bisexual and nonmonosexual (i.e., attracted to more than one gender) women (Coston, 2017), men who have sex with men (Buller et al., 2014, Finneran & Stephenson, 2013; Kubicek, 2018), unique population needs and clinical implications of same-sex partner violence (Rollè et al., 2018; Stiles-Shields & Carroll, 2015), and transgender partner violence (Barrett & Sheridan, 2017). Researchers have also published more general reviews of LGBT partner violence (Brown & Herman, 2015) and barriers to help-seeking for LGBTQ survivors (Calton et al., 2016). Here we attempt to synthesize findings from these reviews, adding more recently published literature, with particular attention to the ecological factors that influence queer couples and the relevance of this research to couples therapy.

Significant limitations of extant sexual minority violence research include: (a) use of predominantly urban convenience samples; (b) lack of a standard definition of partner violence across studies; (c) lack of appropriate strategies to account for potential inclusion of partners in the same relationship in study examples; (d) paucity of longitudinal studies; and (e) failure to describe the exclusion criteria for study participation (Calton et al., 2016; Finneran & Stephenson, 2013). Limitations specific to research with gender minority populations include: (a) grouping transgender people with sexual minorities without collecting gender identity data; (b) focusing on transgender participants (male to female or female to male) but ignoring nonbinary trans people and trans people who have not medically transitioned; and (c) failing to differentiate whether violence was perpetrated by an intimate partner or by a stranger (Barrett & Sheridan, 2017).

Prevalence Rates

The National Intimate Partner and Sexual Violence Survey (Smith et al., 2018) estimates that more than 12 million adults in the United States experience sexual violence, physical violence, and/or stalking victimization by an intimate partner annually. The mental and physical health sequelae related to this violence, as well as macro-level economic and social costs, are significant (Stewart et al., 2016). Current data suggest that partner violence occurs at similar or higher rates in sexual and gender minority relationships when compared to cisgender, heterosexual relationships (Barrett & Sheridan, 2017; Barrett & St. Pierre, 2013; Rollè et al., 2018). Despite this fact, sexual and gender minority populations remain underrepresented in studies investigating the

prevalence, incidence, and dynamics of IPV (Badenes-Ribera et al., 2016; Finneran & Stephenson, 2013; Henry et al., 2018).

In spite of research design limitations, numerous researchers have attempted to document prevalence rates of IPV. Data from the California Health Interview Survey demonstrated significantly higher rates of IPV for gay men and bisexual women when compared with heterosexual men and women (Goldberg & Meyer, 2013). In a meta-analysis of partner violence among self-identified lesbians, lifetime prevalence rates are estimated at 48% for victimization and 15% for victimization in the current relationship, with psychological and emotional violence being the most prevalent form of violence among lesbian couples (Badenes-Ribera et al., 2016). In a systemic review of partner violence among MSM, lifetime prevalence estimates for victimization ranged from 29% to 66% (Finneran & Stephenson, 2013). Rates of victimization among sexual minorities may be particularly high for bisexual and nonmonosexual women (Coston, 2017). Studies conducted with Black, Latinx, and Asian/Pacific Islander sexual minorities have identified prevalence rates that fit within these ranges (Beymer et al., 2017; Feldman et al., 2007; Williams et al., 2015). LGBT adolescents are at a higher risk for dating violence than adults, which in turn increases their risk for violence and other negative health outcomes in adulthood (Edwards, 2018; Whitton et al., 2016) and among queer youth, African Americans are more likely to be victimized than white and Latinx peers (Reuter et al., 2016; Whitton et al., 2016). Among sexual minority women, higher rates of IPV victimization were found in Black women and Latinas compared with white women (Steele et al., 2017). Future prevalence studies of sexual minority IPV victimization should explore within-group differences (e.g., foreign-born and native-born Latinxs), relationship configuration (e.g., monogamous and polyamorous relationships), and IPV across the lifespan.

Prevalence estimates of partner violence among transgender couples have been more difficult to capture, as research historically has grouped partner violence with other forms of violence and hate crimes against transgender people (Goodmark, 2013). However, transgender individuals are estimated to experience partner violence at higher rates than their cisgender peers, including cisgender sexual minorities, with lifetime victimization estimates ranging from 31% to 76% (Henry et al., 2018). Based on data from the 2015 U.S. Transgender Health Survey, Alaska Native/American Indian transgender individuals experienced the highest prevalence of IPV victimization when compared with all other racial/ethnic groups, followed by multiracial and Middle Eastern/North African transgender populations (King et al., 2019).

Risk Factors and Antecedents

The etiology of sexual and gender minority IPV and abuse patterns and dynamics are similar to those identified with cisgender, heterosexual couples such that the abuse tends to recur, escalate, and become increasingly violent over time (Island & Letellier, 1991; Messinger, 2014; Renzetti, 1992). Risk factors for violence victimization across sexual orientations and gender identities include: (a) prior physical violence by an intimate partner; (b) controlling behaviors on the part of the perpetrator; (c) alcohol and drug use; (d) depression; and (e) termination of the relationship (Glass et al., 2008; Rollè et al., 2018). Unfortunately, the majority of existing theories and models about partner violence risk, prevention, and intervention strategies have been developed with cisgender, heterosexual couples and then applied to queer couples; this approach fails to capture the distinct stress, oppression, abuse dynamics, and resilience factors that are specific to sexual and gender minority IPV (Balsam & Szymanski, 2005; Barrett & Sheridan, 2017, Hassouneh & Glass, 2008).

Unique IPV victimization correlates for sexual minority men include sexual risk-taking in the form of unprotected anal sex and HIV-positive status (Beymer et al., 2017; Buller et al., 2014; Feldman et al., 2007). In a focus group study, sexual minority men also identified that struggling

to be the "alpha" (i.e., be the more dominating partner, based in dominant culture masculinity scripts) often led to IPV in same-sex male couples (Goldenberg et al., 2016). For same-sex female couples, fusion—a blurring of boundaries between partners that can erode each partner's autonomy and increase anxiety—has been identified as a unique risk factor for IPV (Kimmes et al., 2017), although some authors have argued that labeling sexual minority women's desire for closeness in relationships as pathological is inaccurate and problematic (Frost & Eliason, 2014). Internalized homophobia has been identified as an IPV risk factor across sexual minorities. For bisexual and nonmonosexual women, internalized biphobia and choosing to come out to a cisgender, male partner, are also associated with IPV (Coston, 2017). Risk factors for gender minorities include coming out as transgender to a partner, beginning to medically transition when a partner is unsupportive, fetishization of transgender bodies—especially by cisgender men, and internalized transphobia (Barrett & Sheridan, 2017). Similar to sexual minorities, previous IPV also increases transgender individuals' likelihood of engaging in unsafe sex (Heintz & Melendez, 2006), which can increase risk of contracting or transmitting HIV (Siemieniuk et al., 2013).

Barriers to Accessing Services

Calton et al. (2016) identified three overarching barriers to seeking help among LGBTQ survivors of partner violence: limited understanding of LGBTQ partner violence, stigma, and systemic inequalities. Many people have difficulty imagining that men can be survivors of partner violence and that women can be perpetrators of partner violence, or they assume that violence must be mutual among same-sex partners (Brown, 2008). Consequently, violence in queer partnerships is often not legitimized and may be viewed as less intense or less hurtful. Biological theories that suggest that men are more aggressive and that same-sex partnerships must not experience the same power differentials as heterosexual partnerships often fuel these detrimental assumptions (Brown, 2008; Burke & Follingstad, 1999). The battered women's movement has also conceptualized the problem of partner violence in terms of a male-female phenomenon, linking violent behavior to men's gender socialization process and adherence to male and female binary gender roles (Miller et al., 2001; Ristock, 2002). In addition, same-sex partner violence is virtually invisible in the media, potentially creating a sense of isolation and discouraging help-seeking among sexual minorities (Estes & Webber, 2017).

Gendered models of partner violence are also problematic for conceptualizing IPV among transgender couples. Many helping professionals do not have adequate training to work with transgender populations, including treatment of transgender victims of partner violence (Barrett & Sheridan, 2017; Seelman, 2015). To our knowledge, there is no research specifically examining media representation of partner violence among gender minorities, suggesting that invisibility and isolation may be even more severe for transgender victims of IPV.

Given the aforementioned dominant culture narratives about partner violence, sexual and gender minority couples may be hesitant to label violence in their relationships as IPV. These couples may believe the violence is normal/expected, they may not want society to view their IPV as a universal flaw about LGBTQ people (Barrett & Sheridan, 2017; Kubicek, 2018), or they may receive dismissive messages and even additional transphobic/homophobic victimization when seeking help from law enforcement (Rollè et al., 2018) and health providers (Ard & Makadon, 2011). For example, many shelters for IPV victims only serve cisgender women, excluding sexual minority men and transgender individuals from their services (Ard & Makadon, 2011). This exclusion is particularly severe for transgender people of color and transgender people with disabilities (Seelman, 2015). In addition, Basow and Thompson (2012) found that domestic violence shelter service providers were less likely to perceive women as victims of IPV when they were in same-sex partnerships. Intersecting cultural identities may make help-seeking more difficult

for sexual and gender minorities of color. For example, in a study of Asian, Pacific Islander, and Native Hawaiian queer women, participants identified shame as a salient cultural construct that prevented victims of IPV from seeking help (Kanuha, 2013). Because of these barriers to identifying IPV and seeking help, sexual and gender minorities are less likely to formally report IPV than their cisgender, heterosexual peers (Calton et al., 2016), and may instead seek informal help from members of their communities (Barrett & Sheridan, 2017; Vaughan & Rodriguez, 2014).

The Sociopolitical Context

Sexual and gender minority couples face additional social issues that cisgender, heterosexual couples do not face; these challenges may make their experiences with partner violence that much more complex. One overarching social issue is that queer couples live in a heterosexist, cissexist society and, despite recent advancements in legal protections for LGBTQ people, experience health disparities, familial rejection, and exposure to a rhetoric of "religious protections," which condones discrimination under the guise of religious freedom (Meyer, 2016). Heterosexism, defined as an ideological system privileging heterosexuality, is threaded throughout all levels of the social structures within which we live (Herek, 1990; Meyer, 2003). Similarly, cissexism is the pervasive ideological system which privileges cisgender individuals and erases/polices gender diversity (Wernick et al., 2017). There are clearly documented negative consequences to queer individuals and couples living in a heterosexist, cissexist society, including increased rates of depression, anxiety, suicide, and alcohol and drug use (Bernhard & Applegate, 1999; Cheng, 2003; Lewis et al., 2003; Mays & Cochran, 2001). Each of these consequences may increase couples' risk for partner violence.

A second social issue specific to queer partner violence has to do with cycle of abuse and power theory. The cycle of violence model (Walker, 1979) proposes that there are three critical phases in the patterns of violent relationships: tension-building, acute battering incidence, and honeymoon phases. This model of violence, however, is defined in heterosexual terms and does not account for the unique aspects of sexual and gender minority abuse dynamics, such as the perpetrator threatening to "out" their partner, questioning the victim's sexual orientation or gender identity and queer community allegiance, or making claims of "mutual abuse." Being "outed" may have serious and detrimental occupational, financial, and social consequences. For example, outing a trans partner who has chosen to be "stealth" in the workplace (i.e., presents as current gender identity without identifying as trans) may leave the trans partner more vulnerable to workplace discrimination based on their transgender identity (Budge et al., 2010). Additional tactics that are often used to exert power over transgender partners include restricting access to medical treatments (e.g., hormones, money for surgery), restricting access to gender-affirmative clothing, touching body parts in ways that the transgender partner experiences as dysphoric, and using the partner's dead name or incorrect pronouns (FORGE, 2013).

A third issue faced by sexual and gender minority couples is the influence of heterosexist and cissexist beliefs on the queer individual (Frost & Meyer, 2009). Meyer (2003) created the minority stress model as a framework for understanding the strain sexual minorities face by living in a heterosexist social environment. The minority stress model has been adapted for transgender and gender nonconforming populations to explain the challenges of living in a cissexist environment (Hendricks & Testa, 2012). Although internalized homophobia is common to the formation of a sexual minority identity, and internalized transphobia to the formation of a gender minority identity, these are not personal traits or internal pathologies; rather, they are the applications of heterosexism and cissexism to the self (Russell & Bohan, 2006). Being in a queer partnership can create couple-level minority stress through stress discrepancies (i.e., when one partner experiences more minority stress than the other) and stress contagion (i.e., when one partner's minority stress spreads to the other partner; Frost et al., 2017).

Consistent with minority stress theory (Meyer, 2003), researchers have consistently found that internalized homophobia negatively impacts queer relationships. For example, both perpetration and victimization of partner violence have been associated with internalized homophobia (Badenes-Ribera et al., 2017; Balsam & Szymanski, 2005; Frost & Meyer, 2009; Kimmes et al., 2017). Overcoming internalized homophobia, therefore, is an essential part of forming a healthy self-concept and correspondingly healthy relationships (Badenes-Ribera et al., 2017; Frost & Meyer, 2009). Further research is needed to thoroughly understand the underlying cognitive mechanisms between internalized homophobia and partner violence perpetration and victimization. In addition, it is likely that internalized transphobia is associated with partner violence (Garthe et al., 2018), an association that should be examined in future studies.

Minority stress theory also posits that queer people of color may experience compounded stress from intersecting systems of oppression (Meyer, 2016). An important area for further research centers around deepening our understanding of how intersecting systems of oppression may increase vulnerability to IPV, and how to increase access and culturally attuned services for queer people with diverse cultural identities and ecological contexts.

Protective Factors

In addition to understanding unique risk factors and barriers for queer couples, we encourage clinicians to identify and build upon the strengths and protective factors of their queer clients. For example, even when sexual and gender minority victims do not feel safe reporting violence to shelters or the police, they may feel comfortable reporting this violence informally to their social networks. For many queer individuals, families of choice—intimate networks of queer people and allies—are strong sources of social support (Barrett & Sheridan, 2017). Vaughan and Rodriguez (2014) highlighted strengths unique to LGBT communities, including resilience, stress-related growth, creativity, courage, authenticity, positive group identity, and open-mindedness. We recommend emphasizing and building on these and other strengths when working with sexual and gender minority couples.

In addition to drawing information from the aforementioned research, it is important that treatment providers examine their own beliefs and values when interpreting and applying research findings to their work with sexual and gender minority populations. Such self-examination increases the likelihood that treatment providers make accurate, cautious conclusions from research findings and deliver queer-affirmative services.

Assessment and Treatment Recommendations

Researchers have demonstrated that once violence begins in a relationship, it is likely to continue and escalate without intervention (Lawson, 2003; O'Leary et al., 1989). Yet, many clinicians have not had formal training about how to assess and intervene with IPV with cisgender, heterosexual couples (Hamberger & Ambuel, 1997), and far fewer have had training on addressing IPV in sexual and gender minority couples (Stiles-Shields & Carroll, 2015). In the following sections, we make general practice recommendations based on our review of the literature and on our clinical experiences, and we provide specific recommendations for each aspect of couples practice with sexual and gender minority couples who are experiencing or who have experienced IPV.

First, clinicians should seek training relevant to sexual and gender minority IPV (Barrett & Sheridan, 2017; Stiles-Shields & Carroll, 2015). We recommend starting with free webinars developed for practitioners treating queer IPV which are available online through the National LGBT Health Education Center and FORGE. Clinicians may also gain training through local workshops, conferences focused on LGBTQ+ populations, and clinical consultation groups. A solid understanding of domestic violence in queer partnerships will increase clinicians' competency

with regard to asking relevant assessment questions, more accurately interpreting couples' verbal responses, and selecting culturally tailored assessment methods and instruments that capture the context of abuse (Stith et al., 2002, 2003, 2004). Second, clinicians should use contextual frameworks to interpret assessment findings. For example, Bronfenbrenner's (1979) ecological model suggests that individuals are influenced by the varied systems in which they live, including their family, friends, work colleagues, legal structures, cultural norms, etc. Utilizing this or other ecological frameworks helps clinicians conceptualize each couples' behavior in context, identify couples' resources and strengths across each level of their ecologies, and identify targets for intervention. Third, clinicians should use caution when interpreting assessment results because most psychometric data has been gathered with predominantly heterosexual, cisgender women (Stephenson et al., 2013). The following sections provide more specific recommendations for various aspects of sexual and gender minority IPV.

Assessment/Screening for Sexual and Gender Minority Partner Violence

We recommend that clinicians screen universally for partner violence as part of every couples intake session, both with intake paperwork and interview. Universal screening reduces the influence of biases and assumptions about who fits the mold of a perpetrator and a victim of violence. Practitioners typically do not conduct partner violence screenings because they lack training and fear clients' reactions (e.g., damaging the therapeutic alliance). Yet clients are likely to support universal partner violence screening when they feel the environment is private, nonjudgmental, non-pressured, and supportive (Todahl & Walters, 2011). As such, practitioners should provide clients with information about why the screening is being conducted, who will have access to the information, and how the information will be used (McNutt et al., 2005; Thackeray et al., 2007).

When clinicians know the gender identities and sexual orientations of each client ahead of time, they should use queer-specific screening tools as part of the intake paperwork. McClennen et al. (2002) developed a partner abuse scale specific to lesbians, with specific attention to power imbalances. Stephenson and colleagues (2013) developed a six-item screening tool for measuring partner violence in gay and bisexual men. Items include HIV-related IPV, as well as monitoring and controlling behaviors, which suggest that IPV operates and should be assessed differently among sexual minority men. Recently, Peitzmeier and colleagues (2019) developed a four-item questionnaire to assess transgender-related IPV, including being forced to conform to an undesired gender presentation and being prevented from accessing hormones, clothing, etc. This measure had adequate reliability and validity in a female-to-male transgender sample. When clinicians do not know the identities of their clients prior to an intake, the clinicians should prepare intake forms and violence screening instruments that do not assume the couple is cisgender and heterosexual.

In addition to screening through intake paperwork, we recommend that practitioners conduct a first-session conjoint meeting with the couple and then immediately follow up with a conversation with each individual to assess for IPV (Bograd & Mederos, 1999). During the initial part of the first session, therapists should spend time joining with the couple and assessing the relationship history and strengths. A principal goal of this first session is to ask what the clients believe are strengths and protective buffers to normative couple conflict in their relationship, such as discrimination stress that queer couples often face. In addition to normalizing couple conflict during the first session, the therapist should clarify that the individual session is a routine part of therapy and explain the therapeutic utility of understanding each partner as an individual in addition to understanding the couple as a unit. This discussion sets the stage for separate sessions and diminishes defensiveness that can occur from scheduling individual meetings. It is advisable that therapists use open-ended questions regarding the couple's conflicts as a nonthreatening precursor to specific screening questions about violent behavior that may be occurring within the relationship.

In the follow-up with each individual client after the conjoint meeting, the clinician can check in with each partner about their responses on intake paperwork, provide screening tools verbally for clients who do not read, and gather information that each partner might not have felt comfortable sharing in front of the other partner. At this point, the clinician conducts further, more in-depth violence assessment and inquiry if the results of this initial screen suggest that violence is presently occurring or if the client indicates feeling unsafe in the relationship (Todahl & Walters, 2009). In addition, it is essential that the therapist assesses each partner's substance use, depression, suicidality, and the extent of psychological abuse because these factors commonly link and are reciprocally influenced by partner violence (Stith, 2000).

We also recommend that therapists ask about partner violence in a nonjudgmental way and ask about specific acts of violence because clients will often define violence differently (Stith, 2000). Therapists might ask, for example, "Specifically, how do you resolve conflicts?" and "Have you ever slapped, pushed, kicked, etc. your partner or had these done to you?" (Lawson, 2003). In a partnership in which only one partner is transgender, or in which one partner is a sexual minority and the other is not, therapists should also be aware of how the non-queer partner may be utilizing tactics that undermine and oppress the queer partner's identity, such as threating to "out" the partner, saying that the partner is "not a real man" or "not actually bisexual," or touching one's partner in a way known to trigger gender dysphoria for the partner (Coston, 2017; FORGE, 2013). It is also important to ask about each partner's perception of danger and fear in the relationship. Weisz et al. (2000) found that the victim's perceived risk for severe assault is a significant predictor of the level of danger in the relationship. In addition, assessing the level at which the perpetrator is willing to take responsibility for the violence is essential in determining if conjoint treatment is safe and indicated. If it is determined that conjoint therapy is not appropriate because of ongoing violence and safety concerns in the relationship, we recommend that the therapist have an open conversation with the clients individually or as a couple regarding concerns about meeting conjointly. A clinician can present the recommendation against conjoint therapy as the beneficial step toward helping them meet their relationship goals. Using client language, motivations for change, and focusing on the clients' desired goals are essential for building trust in this conversation, especially for clients who have had negative experiences with health care providers in the past.

If the therapist decides that conjoint therapy would not be safe and thus recommends individual meetings, we suggest the therapist offer clear, specific steps for clients to follow in order to resume conjoint sessions in the future. Rather than turn the couple away, we recommend working with clients toward their goals if they are both willing to engage in creating change in the relationship and agree to follow the therapist's recommendations. For example, the therapist can encourage the offending partner to take anger management classes, engage in groups that focus on emotional regulation, or participate in partner violence classes when available. Therapists should first ascertain that classes they recommend are queer-affirming, as groups that perpetuate heterosexist and cissexist beliefs about relationships could further exacerbate the client's pain and make healing and change more difficult. The therapist can also suggest that clients consistently and successfully implement a time-out contract before conjoint sessions are considered (Rosen et al., 2003). In addition, we recommend the therapist maintain individual sessions until conjoint therapy is indicated (i.e., the perpetrator takes responsibility for the violence, and the violence decreases). Because a history of IPV victimization can make it difficult to negotiate safer sex with partners, Beymer and colleagues (2017) emphasized the importance of supporting African-American MSM in accessing pre-exposure prophylaxis (PrEP) medications to prevent HIV infection in high-risk individuals. Understanding that IPV victimization increases HIV risk for sexual minority men and higher-risk gender minorities is critical to providing queer-affirmative support for this population.

Treatment of Sexual and Gender Minority Partner Violence

If after conducting a thorough assessment of relationship safety and violence in the relationship the therapist determines that it is appropriate to do couples therapy, then we recommend the therapist follow the treatment model developed and tested by Stith and colleagues (2005). These researchers recommend conjoint couples treatment modality for those couples who: (a) engage in low-level partner violence; (b) do not misuse substances; (c) want to remain a couple; and (d) want to end the violence. Conjoint treatment for partner violence may be controversial, but not all violent couples are alike; as such, different treatment approaches are warranted. We also maintain that conjoint treatment is warranted in some cases because it is common for both partners in the relationship to be violent, and cessation of partner violence by one partner is highly dependent on whether the other partner also ceases. Furthermore, separate groups (i.e., anger management, support groups) often do not address the underlying relationship dynamics that may affect each partner's decision to remain in the relationship (Stith et al., 2005). A case study is be introduced next and then weaved into the remaining sections to illustrate how treatment concepts and interventions can be applied.

Case Study

Kal and Laurie presented for couples therapy. Kal reported on the intake forms that she identified as a 38-year-old transgender, queer white woman; she reported concerns about an increase in arguments with her partner over the past year and worry about the negative impacts on their relationship. Laurie reported on her intake forms that she identified as a 42-year-old cisgender, pansexual, African American and European American woman, and reported concerns about her relationship with Kal.

The therapist explained that they would first meet all together and, as a routine procedure for working with couples, they would then each meet individually the following session for an overall health screen. During their first meeting the therapist explored the couple's concerns, including societal challenges that they faced as a queer couple, and inquired about the couple's strengths that buffered conflict within the relationship. Kal and Laurie identified shared love of the outdoors, resilience in the face of economic and familial challenges, and support from their family of choice as strengths in their relationship. The couple reported that they typically did not talk about conflictual topics until there was a "blow out."

The therapist used the individual session time following the joint session to further explore each partner's individual and relationship history and current contextual supports and barriers. Most importantly, the therapist assessed for partner violence by exploring their conflicts, gathering data regarding their behaviors during an argument, and determining the level of danger in the relationship. During their individual meetings, the therapist learned that Kal was significantly more out to family and coworkers than Laurie, which had created a significant amount of stress for the couple (Knoble & Linville, 2012). The therapist asked the clients about their outness, "As I aim to understand your unique experiences, can you tell me about when/if you have come out and what that has been like for you over time?" The therapist asked about outness within families of origin, social relationships, and work and school environments. Then, the therapist explored more specifically about their noted experiences, while simultaneously considering their outness as a couple.

Knowing that Kal and Laurie have unique experiences given their intersecting identities (Crenshaw, 1991), the therapist explored more about how their differing levels of outness are influenced by their other salient identities. Laurie expressed that her experiences as a woman of color have greatly shaped her willingness to be out at work. Through a brief discussion, the covert and overt racism that Laurie has already experienced at work guided her willingness to share more intimate parts of herself with her colleagues. Likewise, given the fear her family has

about maintaining safety as a woman of color, Laurie shared that she did not want to be out to family and give them additional reasons to be concerned about her well-being. Given space to discuss, Kal was able to build more compassion for their differing experiences and asked to discuss more in future sessions. From the lens of intersectionality (Crenshaw, 1991), therapists can build awareness within the couple and the therapy process as to the unique experiences at the intersection of racism, cissexism, ableism, and other systems of oppression.

In response to partner violence screening questions, Kal shared that she had always felt safe with Laurie, but that sense of safety wavered a bit two months ago when Laurie was drinking, got mad, and threw a plate at the wall near where Kal was standing while yelling that Kal "was not a real woman." Upon further questioning, Kal did not disclose any other incidents that concerned her, noting the argument with the plate as the worst it has been. Laurie reported feeling deeply sorry for the incident. Both partners expressed feeling safe and when asked directly by the therapist, both were willing to discuss their arguments in the couple's sessions.

After considering information from the couples and individual sessions, the therapist determined that it would be appropriate to continue treating the couple in joint sessions because: (a) Kal and Laurie each consented to continue couples therapy; (b) each expressed that they felt safe talking with each other about their relationship and their conflicts; (c) assessment results of substance use by both partners were minimal; and (d) intake and interview assessment results evidenced that the level of abuse experienced in their relationship was minimal. The therapist informed Kal and Laurie that her approach would involve conducting ongoing "safety checks" throughout their argument cycle. In addition, the therapist also developed a time-out contract for the remainder of treatment. Finally, the therapist asked the couple if they had any questions or concerns about her or the counseling process that they would like to talk about. When the couple asked if their experience was "normal," the therapist provided psychoeducation about queer IPV and gave the couple resources from FORGE (http://forge-forward.org/anti-violence/for-professionals/), which focuses on supporting transgender victims of IPV and the Network/la Red (http://tnlr.org), a survivor-led organization for queer victims of partner abuse.

Ongoing treatment considerations for Kal and Laurie include regular assessment of partner violence and substance use during the course of treatment, ongoing assessment of the use and success of the time-out contract, the role that outness has within their relationship, and acknowledgement and amplification of what is working well within the relationship. In addition, it is imperative for the therapist to receive ongoing consultation and supervision to be aware of any developing countertransference with this client system.

Therapeutic Framework and Strategies

We recommend that therapists use a solution-oriented, strengths-focused framework to guide therapy with queer couples dealing with partner violence (Lipchik & Kubicki, 1996; Stith, 2000). As demonstrated in the case study, therapists can collect information from the couple about what they see as strengths and protective factors in their relationship and community during the first session. Therapists should focus on helping couples see the possibilities for their relationship, determine if they can manage conflict in a nonviolent way, and understand how their individual, couple, and community resources can contribute to healthier patterns in their relationship. For example, chosen family and ethnic community ties may be very important to each partner in the case study, and they may consider these ties essential to their individual and relational health. Practitioners can help couples identify and describe their individual, relational, and community strengths and resiliencies, with integration of the strengths of LGBT populations outlined by Vaughan and Rodriguez (2014).

When therapists focus on what is working well in the relationship and amplify change (O'Hanlon & Weiner-Davis, 1989) while not minimizing the violence or its impact, it is likely that couples will feel more valued for their strength and coping skills (Green, 2004), less judged, and more open to working on their relationship. Therapists may also increase openness to treatment by providing psychoeducation about partner violence among queer couples, including discussing that partner violence occurs, at least in part, due to the systemic oppression that queer individuals and couples face (Rollè et al., 2018). As recommended by Stith (2000), we also suggest that co-therapy teams work with queer couples who want to end the violence in their relationship when possible. A co-therapy arrangement enables therapists to meet individually with each partner, both before and after the session, so that they can do "safety checks," ask whether violence has occurred between sessions, discuss the perceived risk level, and conduct safety planning as needed. A co-therapy arrangement may be particularly helpful when one of the therapists has minimal experience working with queer couples, as co-therapy can create accountability to provide more queer-affirming services and space to consult with the more experienced co-therapist. In addition, by having co-therapists, each therapist can meet separately but simultaneously with each partner, reducing the time that these safety checks will take. For example, in future sessions of the case study, Kal and Laurie could each meet with a co-therapist for the first 10–15 minutes of the session to discuss safety in the relationship and then have the rest of the session to focus on couples therapy goals. Creative brainstorming with clients in terms of safety planning may be especially warranted in a queer partnership because, as detailed earlier, queer victims of IPV face many barriers to accessing social services.

We also recommend developing a negotiated time-out procedure with the couple early in treatment (Rosen et al., 2003), which includes the following components: (a) being aware of internal cues that anger is escalating; (b) deciding when anger is escalating past either partner's safety zone and a time-out is needed; (c) initiating a time-out with an agreed-upon signal; (d) acknowledging time-out; (e) disengaging by going to separate locations; (f) engaging in calming activities; and (g) returning and reconnecting if calm. Therapists are encouraged to have each partner sign a "no violence contract" at the beginning of therapy; this contract should be revisited as needed throughout the therapy process.

Returning to the case study, the clients discussed the time-out procedure after the individual sessions so that the couple had a strategy when escalation occurs. Kal and Laurie both discussed how they know anger is internally present by describing it within their body; Kal noted how she would initiate a time-out with raising of her hand and Laurie agreed. For the duration of the time-out, Laurie shared that she would spend time going on a walk and Kal shared she would go read in the bedroom. The couple agreed that they would meet in the kitchen when they felt calmer with the aim of the time-out lasting about 30–40 minutes. The therapist asked the couple to share in session after the first time-out is enacted in order to explore any changes needed to maximize effectiveness.

Finally, it is important for therapists to know about other resources for dealing with violence in their local community. Therapists should not assume that local domestic violence shelters are a safe and available resource for sexual and gender minorities. It is essential to know which shelters, treatment programs, and legal and law enforcement professionals are open and able to competently address queer partner violence. Knowledge about community resources and collaborative partnerships will help therapists develop realistic safety plans with their clients and help clients access the services they need. Therapists may also need to provide consultation and education about queer partner violence to other professionals in the community. In addition, we recommend that practitioners refer couples and other professionals to queer partner violence resources, including FORGE and the Network/la Red.

Creating a Safe Therapeutic Environment

The therapist is charged with providing a nonjudgmental, safe, and open environment for queer couples who are dealing with violence. It is essential that therapists—including those who identify as queer—examine the ways in which heterosexism and cissexism have shaped their own personal and professional lives (Barrett & Sheridan, 2017; McGeorge & Carlson, 2011) and how these biases may influence screening and treatment of partner violence in queer couples. We also recommend that therapists reflect on and increase their self-awareness regarding biases they may have about partner violence. Therapists must be able to facilitate disclosure of the abuse and then be able to handle the disclosure in a way that fosters safety and hope. It is paramount, therefore, that therapists be patient and empathetic and recognize that the victim of the partner violence may choose to stay in the relationship (Peterman & Dixon, 2003).

Helpful strategies for welcoming queer clients include "coming out" as a queer-affirmative therapist, communicating a queer-affirmative stance in therapy, and helping queer couples deconstruct the influences of cissexism and heterosexism throughout the therapy process (McGeorge & Carlson, 2011). Asking questions about the gender of a person's partner rather than making assumptions (Matthews, 2007), placing materials (e.g., magazines, books) in the waiting room that represent culturally diverse queer individuals and relationships, and helping queer couples give voice to how living in a heterosexist, cissexist society affects them as individuals and affects their relationships are examples of affirming practices (McGeorge & Carlson, 2011).

Supervision and Consultation

In addition to the recommendations described, it is imperative that therapists seek regular consultation with a supervisor, peers, and/or a consultation team to address normative issues of countertransference that can arise when working with IPV. Consultation can also provide the therapist with key support and/or knowledge, which in turn can enable the therapist to better support clients. For example, clinicians can use cross-cultural consultation experiences to increase their awareness of their sexist, gendered, transphobic, heterosexist, and homophobic biases and assumptions. In addition to increasing awareness, supervisors are encouraged to ask clinicians specific questions about their practices in the therapy room to assess the influences of their biases and assumptions. We recommend that supervisors ask clinicians about their assumptions, how their assumptions are informed, and assess how supervisees are navigating the intersection of identity and IPV. Supervisors may need to redirect clinicians to key resources and/or seek resources themselves to ensure best practices for the intersection of IPV with gender and sexual minorities.

Recommendations for Future Research

Sexual and gender minority IPV is a relatively new area of study, and there are many research questions yet to be explored. Future studies should continue to investigate the unique risk and protective factors, correlates, and treatment of sexual and gender minority IPV. We recommend developing and testing interventions to help prevent and dispel myths about queer IPV. We also recommend continuing to test and improve screening measures with diverse sexual and gender minority populations, and to examine how such screening measures can be implemented in a variety of settings (e.g., hospitals, community mental health agencies). Finally, we recommend researching the etiology and treatment of queer IPV in populations with unique clinical needs, including queer people living in rural areas who do not have easy access to mental health services, as well as multicultural queer communities for whom additional cultural considerations in the treatment of IPV are necessary for providing quality care.

Conclusion

Prevalence rates and the etiology of partner violence for sexual and gender minority relationships are similar to those of cisgender, heterosexual relationships, but queer partnerships face additional stigma and barriers that add to experiences of suffering and isolation. Therefore, it is imperative that researchers, clinicians, and policy makers break down the barriers for sexual and gender minority partners who are seeking the necessary support and treatment. We recommend utilizing a universal screening protocol for partner violence among all couples, regardless of their sexual orientation and gender identity. In addition, therapists can employ a strengths-focused, empowerment approach to treatment and use strategies that increase safety, healthy communication, and positive social support. Screening, assessment, and treatment of partner violence with minority couples require therapists to be knowledgeable of the sociocultural needs of marginalized groups. Researchers need to include sexual and gender minority couples in the ongoing study of the most effective approaches to assessment, treatment strategies, and therapeutic modalities in order to end partner violence. In addition, as helping professionals, we must specifically explore and expand our understanding of the unique assessment and treatment needs of sexual and gender minority partnerships.

References

Ard, K. L., & Makadon, H. J. (2011). Addressing intimate partner violence in lesbian, gay, bisexual, and transgender patients. *Journal of General Internal Medicine, 26*(8), 930–933. https://doi.org/10.1007/s11606-011-1697-6

Badenes-Ribera, L., Bonilla, A., Frias, D., Pons, G., & Monterde-i-Bort, H. (2016). Intimate partner violence in self-identified lesbians: A systemic review of its prevalence and correlates. *Trauma, Violence & Abuse, 17*(3), 284–297. https://doi.org/10.1177/1524838015584363

Badenes-Ribera, L., Sánchez-Meca, J., & Longobardi, C. (2017). The relationship between internalized homophobia and intimate partner violence in same-sex relationships: A meta-analysis. *Trauma, Violence, & Abuse, 20*(3), 331–343. https://doi.org/10.1177/1524838017708781

Balsam, K., & Szymanski, D. (2005). Relationship quality and domestic violence in women's same-sex relationships: The role of minority stress. *Psychology of Women Quarterly, 29*(3), 258–269. https://doi.org/10.1111/j.1471-6402.2005.00220.x

Barrett, B. J., & Sheridan, D. V. (2017). Partner violence in transgender communities: What helping professionals need to know. *Journal of GLBT Family Studies, 13*(2), 137–162. https://doi.org/10.1080/1550428X.2016.1187104

Barrett B. J., & St. Pierre, M. (2013). Intimate partner violence reported by lesbian-, gay-, and bisexual-identified individuals living in Canada: An exploration of within group variations. *Journal of Gay and Lesbian Social Services, 25*(1), 1–23. https://doi.org/10.1080/10538720.2013.751887

Basow, S. A., & Thompson, J. (2012). Service providers' reactions to intimate partner violence as a function of victim sexual orientation and type of abuse. *Journal of Interpersonal Violence, 27*(7), 1225–1241. https://doi.org/10.1177/0886260511425241

Bernhard, L., & Applegate, J. (1999). Comparison of stress and stress management strategies between lesbian and heterosexual women. *Health Care for Women International, 20*(4), 335–347. https://doi.org/10.1080/073993399245647

Beymer, M., Harawa, N., Weiss, R., Shover, C., Toynes, B., Meanley, S., & Bolan, R. (2017). Are partner race and intimate partner violence associated with incident and newly diagnosed HIV infection in African-American men who have sex with men? *Journal of Urban Health, 94*(5), 666–675. https://doi.org/10.1007/s11524-017-0169-7

Bograd, M., & Mederos, F. (1999). Battering and couples therapy: Universal screening and selection of treatment modality. *Journal of Marital and Family Therapy, 25*(3), 291–312. https://doi.org/10.1111/j.1752-0606.1999.tb00249.x

Bronfenbrenner, U. (1979). *The ecology of human development*. Harvard University Press.

Brown, C. (2008). Gender-role implications on same-sex intimate partner abuse. *Journal of Family Violence, 23*(6), 457–462. https://doi.org/10.1007/s10896-008-9172-9

Brown, T. N. T., & Herman, J. L. (2015). *Intimate partner violence and sexual abuse among LGBT people: A review of existing research.* Williams Institute, UCLA School of Law. https://williamsinstitute.law.ucla.edu/wp-content/uploads/Intimate-Partner-Violence-and-Sexual-Abuse-among-LGBT-People.pdf

Browne, A., Salomon, A., & Bassuk, S. S. (1999). The impact of recent partner violence on poor women's capacity to maintain work. *Violence Against Women, 5*(4), 393–426. https://doi.org/10.1177/10778019922181284

Budge, S. L., Tebbe, E. N., & Howard, K. A. S. (2010). The work experiences of transgender individuals: Negotiating the transition and career decision-making processes. *Journal of Counseling Psychology, 57*(4), 377–393. https://doi.org/10.1037/a0020472

Buller, A. M., Devries, K. M., Howard, L. M., & Bacchus, L. J. (2014). Associations between intimate partner violence and health among men who have sex with men: A systematic review and meta-analysis. *PLOS Medicine, 11*(3), e1001609. https://doi.org/10.1371/journal.pmed.1001609

Burke, L. K., & Follingstad, D. R. (1999). Violence in lesbian and gay relationships: Theory, prevalence, and correlational factors. *Clinical Psychology Review, 19*(5), 487–512. https://doi.org/10.1016/S0272-7358(98)00054-3

Calton, J. M., Cattaneo, L. B., & Gebhard, K. T. (2016). Barriers to help seeking for lesbian, gay, bisexual, transgender, and queer survivors of intimate partner violence. *Trauma, Violence, and Abuse, 17*(5), 585–600. https://doi.org/10.1177/1524838015585318

Cheng, Z. (2003). Issues and standards in counseling lesbians and gay men with substance abuse concerns. *Journal of Mental Health Counseling, 25*(4), 323–336. https://doi.org/10.17744/mehc.25.4.nb107j9cqdc5j7ld

Chronister, K. M., & McWhirter, E. H. (2003). Applying social cognitive career theory to the empowerment of battered women. *Journal of Counseling and Development, 81*(4), 418–424. https://doi.org/10.1002/j.1556-6678.2003.tb00268.x

Coston, B. M. (2017). Power and inequality: Intimate partner violence against bisexual and non-monosexual women in the United States. *Journal of Interpersonal Violence,* 886260517726415. https://doi.org/10.1177/0886260517726415

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review, 43*(6), 1241–1299. https://doi.org/10.2307/1229039

Edwards, K. M. (2018). Incidence and outcomes of dating violence victimization among high school youth: The role of gender and sexual orientation. *Journal of Interpersonal Violence, 33*(9), 1472–1490. https://doi.org/10.1177/0886260515618943

Estes, M. L., & Webber, G. R. (2017). "More closeted than gayness itself": The depiction of same-sex couple violence in newspaper media. *Journal of Interpersonal Violence*. https://doi.org/10.1177/0886260517736271

Feldman, M. B., Ream, G. L., Díaz, R. M., & El-Bassel, N. (2007). Intimate partner violence and HIV sexual risk behavior among Latino gay and bisexual men: The role of situational factors. *Journal of LGBT Health Research, 3*(4), 75–87. https://doi.org/10.1080/15574090802226618

Finneran, C., & Stephenson, R. (2013). Intimate partner violence among men who have sex with men: A systematic review. *Trauma, Violence, and Abuse, 14*(2), 168–185. https://doi.org/10.1177/1524838012470034

FORGE. (2013). *Trans-specific power and control tactics.* http://forge-forward.org/wp-content/docs/power-control-tactics-categories_FINAL.pdf

Frost, D. M., & Eliason, M. J. (2014). Challenging the assumption of fusion in female same-sex relationships. *Psychology of Women Quarterly, 38*(1), 65–74. https://doi.org/10.1177/0361684313475877

Frost, D. M., LeBlanc, A. J., de Vries, B., Alston-Stepnitz, E., Stephenson, R., & Woodyatt, C. (2017). Couple-level minority stress: An examination of same-sex couples' unique experiences. *Journal of Health and Social Behavior, 58*(4), 455–472. https://doi.org/10.1177/0022146517736754

Frost, D. M., & Meyer, I. H. (2009). Internalized homophobia and relationship quality among lesbians, gay men, and bisexuals. *Journal of Counseling Psychology, 56*(1), 97–109. https://doi.org/10.1037/a0012844

Garthe, R. C., Hidalgo, M. A., Hereth, J., Garofalo, R., Reisner, S. L., Mimiaga, M. J., & Kuhns, L. (2018). Prevalence and risk correlates of intimate partner violence among a multisite cohort of young transgender women. *LGBT health, 5*(6), 333–340. https://doi.org/10.1089/lgbt.2018.0034

Glass, N., Perrin, N., Hanson, G., Bloom, T., Gardner, E., & Campbell, J. C. (2008). Risk for reassault in abusive female same-sex relationships. *American Journal of Public Health, 98*(6), 1021–1027. https://doi.org/10.2105/AJPH.2007.117770

Goldberg, N. G., & Meyer, I. H. (2013). Sexual orientation disparities in history of intimate partner violence: Results from the California Health Interview Survey. *Journal of Interpersonal Violence*, *28*(5), 1109–1118. https://doi.org/10.1177/0886260512459384

Goldenberg, T., Stephenson, R., Freeland, R., Finneran, C., & Hadley, C. (2016). "Struggling to be the alpha": Sources of tension and intimate partner violence in same-sex relationships between men. *Culture, Health and Sexuality, 18*(8), 875–889. https://doi.org/10.1080/13691058.2016.1144791

Goodmark, L. (2013). Transgender people, intimate partner abuse, and the legal system. *Harvard Civil Rights-Civil Liberties Law Review, 48,* 51–104. https://digitalcommons.law.umaryland.edu/fac_pubs/1460/

Green, R. (2004). Risk and resilience in lesbian and gay couples: Comment on Solomon, Rothblum, and Balsam (2004). *Journal of Family Psychology, 18*(2), 290–292. https://doi.org/10.1037/0893-3200.18.2.290

Hamberger, L., & Ambuel, B. (1997). Training psychology students and professionals to recognize and intervene into partner violence: Borrowing a page from medicine. *Psychotherapy, 34*(4), 375–385. https://doi.org/10.1037/h0087782

Hassouneh, D., & Glass, N. (2008). The influence of gender role stereotyping on women's experiences of female same-sex intimate partner violence. *Violence Against Women, 14*(3), 310–325. https://doi.org/10.1177/1077801207313734

Hays, P. A. (2001). *Addressing cultural complexities in practice: A framework for clinicians and counselors.* American Psychological Association. https://doi.org/10.1037/10411-000

Heintz, A. J., & Melendez, R. M. (2006). Intimate Partner Violence and HIV/STD Risk Among Lesbian, Gay, Bisexual, and Transgender Individuals. *Journal of Interpersonal Violence*, *21*(2), 193–208. https://doi.org/10.1177/0886260505282104

Hendricks, M. L., & Testa, R. J. (2012). A conceptual framework for clinical work with transgender and gender nonconforming clients: An adaptation of the minority stress model. *Professional Psychology: Research and Practice, 43*(5), 460–467. https://doi.org/10.1037/a0029597

Henry, R. S., Perrin, P. B., Coston, B. M., & Calton, J. M. (2018). Intimate partner violence and mental health among transgender/gender nonconforming adults. *Journal of Interpersonal Violence*. https://doi.org/10.1177/0886260518775148

Herek, G. (1990). The context of anti-gay violence: Notes on cultural and psychological heterosexism. *Journal of Interpersonal Violence, 5*(3), 316–333. https://doi.org/10.1177/088626090005003006

Hill, N. A., Woodson, K. M., Ferguson, A. D., & Parks, C. W. (2012). Intimate partner abuse among African American lesbians: Prevalence, risk factors, theory, and resilience. *Journal of Family Violence, 27*(5), 401–413. https://doi.org/10.1007/s10896-012-9439-z

Hook, J. N., Davis, D. E., Owen, J., Worthington, E. L., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology, 60*(3), 353–366. https://doi.org/10.1037/a0032595

Island, D., & Letellier, P. (1991). *Men who beat the men who love them: Battered gay men and domestic violence.* Haworth.

Kanuha, V. (1994). Women of color in battering relationships. In L. G. Comas-Diaz & B. Greene (Eds.), *Women of color: Integrating ethnic and gender identities in psychotherapy* (pp. 428–454). Guilford.

Kanuha, V. K. (2013). "Relationships so loving and so hurtful": The constructed duality of sexual and racial/ethnic intimacy in the context of violence in Asian and Pacific Islander lesbian and queer women's relationships. *Violence Against Women, 19*(9), 1175–1196. https://doi.org/10.1177/1077801213501897

Kimmes, J. G., Mallory, A. B., Spencer, C., Beck, A. R., Cafferky, B., & Stith, S. M. (2017). A meta-analysis of risk markers for intimate partner violence in same-sex relationships. *Trauma, Violence, & Abuse, 20*(3), 374–384. https://doi.org/10.1177/1524838017708784

King, W. M., Restar, A., & Operario, D. (2019). Exploring multiple forms of intimate partner violence in a gender and racially/ethnically diverse sample of transgender adults. *Journal of Interpersonal Violence*. https://doi.org/10.1177/0886260519876024

Knoble, N. B., & Linville, D. (2012), Outness and relationship satisfaction in same-gender couples. *Journal of Marital and Family Therapy, 38*(2), 330–339. https://doi.org/10.1111/j.1752-0606.2010.00206.x

Kubicek, K. (2018). Setting an agenda to address intimate partner violence among young men who have sex with men: A conceptual model and review. *Trauma, Violence, and Abuse, 19*(4), 473–487. https://doi.org/10.1177/1524838016673599

Lawson, D. (2003). Incidence, explanations and treatment of partner violence. *Journal of Counseling and Development, 81*(1), 19–32. https://doi.org/10.1002/j.1556-6678.2003.tb00221.x

Lewis, R., Derlega, V., Griffin, J., & Krowinski, A. (2003). Stressors for gay men and lesbians: Life stress, gay-related stress, stigma consciousness, and depressive symptoms. *Journal of Social and Clinical Psychology, 22*(6), 716–729. https://doi.org/10.1521/jscp.22.6.716.22932

Lipchik, E., & Kubicki, A. (1996). Solution-focused domestic violence views: Bridges toward a new reality in couples therapy. In S. D. Miller, M. A. Hubble, & B. L. Duncan (Eds.), *Handbook of solution-focused brief therapy* (pp. 65–97). Jossey Bass.

Marganski, A., & Melander, L. (2018). Intimate partner violence victimization in the cyber and real world: Examining the extent of cyber aggression experiences and its association with in-person dating violence. *Journal of Interpersonal Violence, 33*(7), 1071–1095. https://doi.org/10.1177/0886260515614283

Matthews, C. (2007). Affirmative lesbian, gay, and bisexual counseling with all clients. In K. J. Bieschke, R. M. Perez, & K. A. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, bisexual and transgender clients* (2nd ed., pp. 201–219). American Psychological Association. https://doi.org/10.1037/11482-008

Mays, V., & Cochran, S. (2001). Mental health correlates and perceived discrimination among lesbian, gay and bisexual adults in the United States. *American Journal of Public Health, 91*(11), 1869–1876. https://doi.org/10.2105/AJPH.91.11.1869

McClennen, J., Summers, A., & Daley, J. (2002). The lesbian partner abuse scale. *Research on Social Work Practice, 12*(2), 277–292. https://doi.org/10.1177/104973150201200205

McGeorge, C., & Carlson, T. (2011). Deconstructing heterosexism: Becoming an LGB affirmative heterosexual couple and family therapist. *Journal of Marital and Family Therapy, 37*(1), 14–26. https://doi.org/10.1111/j.1752-0606.2009.00149.x

McNutt, L., Waltermaurer, E., McCauley, J., Campbell, J., & Ford, D. (2005). Rationale for development of the computerized intimate partner violence screen for primary care. *Family Violence Prevention & Health Practice, 3,* 1–13.

Messinger, A. M. (2014). Marking 35 years of research on same-sex intimate partner violence: Lessons and new directions. In D. Peterson & V. Panfil (Eds.), *Handbook of LGBT communities, crime, and justice* (pp. 65–85). Springer. https://doi.org/10.1007/978-1-4614-9188-0_4

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: conceptual issues and research evidence. *Psychological Bulletin, 129*(5), 674–697. https://doi.org/10.1037/0033-2909.129.5.674

Meyer, I. H. (2016). The elusive promise of LGBT equality. *American Journal of Public Health, 106*(8), 1356–1358. https://doi.org/10.2105/AJPH.2016.303221

Miller, D., Greene, K., Causby, V., White, B., & Lockhart, L. (2001). Domestic violence in lesbian relationships. In E. Kaschak (Ed.), *Intimate betrayal: Domestic violence in lesbian relationships* (pp. 107–128). Haworth. https://doi.org/10.1300/J015v23n03_08

O'Hanlon, W., & Weiner-Davis, M. (1989). *In search of solutions: A new direction in psychotherapy*. Norton.

O'Leary, K., Barling, J., Arias, I., Rosenbaum, A., Malone, J., & Tyree, A. (1989). Prevalence and stability of physical aggression between spouses: A longitudinal analysis. *Journal of Consulting and Clinical Psychology, 57*(2), 263–268. https://doi.org/10.1037/0022-006X.57.2.263

Peitzmeier, S. M., Hughto, J., Potter, J., Deutsch, M., & Reisner, S. (2019). Development of a novel tool to assess intimate partner violence against transgender individuals. *Journal of Interpersonal Violence, 34*(11), 2376–2397. https://doi.org/10.1177/0886260519827660

Peterman, L., & Dixon, C. (2003). Domestic violence between same-sex partners: Implications for counseling. *Journal of Counseling and Development, 81*(1), 40–47. https://doi.org/10.1002/j.1556-6678.2003.tb00223.x

Renzetti, C. (1992). *Violent betrayal: Partner abuse in lesbian relationships.* Sage. https://doi.org/10.4135/9781483325767

Reuter, T., Newcomb, M., Whitton, S., & Mustanski, B. (2016). Intimate partner violence victimization in LGBT young adults: Demographic differences and associations with health behaviors. *Psychology of Violence, 7*(1), 101–109. https://doi.org/10.1037/vio0000031

Ristock, J. (2002). *No more secrets: Violence in lesbian relationships.* Routledge.

Rollè, L., Giardina, G., Caldarera, A. M., Gerino, E., & Brustia, P. (2018). When intimate partner violence meets same sex couples: A review of same sex intimate partner violence. In L. Rollè, S. Ramon, & P. Brustia (Eds.), *New perspectives on domestic violence: From research to intervention* (pp. 50–62). Frontiers Media. https://doi.org/10.3389/978-2-88945-870-7

Rosen, K., Matheson, J., Stith, S., McCollum, E., & Locke, L. (2003). Negotiated time-out: A de-escalation tool for couples. *Journal of Marital and Family Therapy, 29*(3), 291–298. https://doi.org/10.1111/j.1752-0606.2003.tb01207.x

Russell, G. M., & Bohan, J. S. (2006). The case of internalized homophobia. *Theory and Psychology, 16*(3), 343–366. https://doi.org/10.1177/0959354306064283

Saltzman, L. E., Fanslow, J. L., McMahon, P. M., & Shelley, G. A. (2002). *Intimate partner violence surveillance: Uniform definitions and recommended data elements, Version 1.0.* National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Seelman, K. (2015). Unequal treatment of transgender individuals in domestic violence and rape crisis programs. *Journal of Social Service Research, 41*(3), 307–325. https://doi.org/10.1080/01488376.2014.987943

Siemieniuk, R., Krentz, H., & Gill, M. (2013). Intimate partner violence and HIV: A review. *Current HIV/AIDS Reports, 10*(4), 380–389. https://doi.org/10.1007/s11904-013-0173-9

Smith, S. G., Zhang, X., Basile, K. C., Merrick, M. T., Wang, J., Kresnow, M., Chen, J. (2018). *The National Intimate Partner and Sexual Violence Survey (NISVS): 2015 data brief – Updated release.* National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Steele, S. M., Everett, B. G., & Hughes, T. L. (2017). Influence of perceived femininity, masculinity, race/ethnicity, and socioeconomic status on intimate partner violence among sexual-minority women. *Journal of Interpersonal Violence, 35*(1–2), 453–475. https://doi.org/10.1177/0886260516683176

Stephenson, R., Hall, C. D., Williams, W., Sato, K., & Finneran, C. (2013). Towards the development of an intimate partner violence screening tool for gay and bisexual men. *The Western Journal of Emergency Medicine, 14*(4), 390–400. https://doi.org/10.5811/westjem.3.2013.15597

Stewart, D., Vigod, S., & Riazantseva, E. (2016). New developments in intimate partner violence and management of its mental health sequelae. *Current Psychiatry Reports, 18*(1), 4. https://doi.org/10.1007/s11920-015-0644-3

Stiles-Shields, C., & Carroll, R. A. (2015). Same-sex domestic violence: Prevalence, unique aspects, and clinical implications. *Journal of Sex and Marital Therapy, 41*(6), 636–648. https://doi.org/10.1080/0092623X.2014.958792

Stith, S. (2000). Clinical update: Domestic violence. *American Association for Marriage and Family Therapy, 2*(3), 1–7.

Stith, S. M., McCollum, E. E., Rosen, K. H., Locke, L. D., & Goldberg, P. D. (2005). Domestic violence-focused couples treatment. In J. L. Lebow (Ed.), *Handbook of clinical family therapy* (pp. 406–430). Wiley.

Stith, S. M., Rosen, K. H., & McCollum, E. E. (2002). Developing a manualized couples treatment for domestic violence: Overcoming challenges. *Journal of Marital and Family Therapy, 28*(1), 21–25. https://doi.org/10.1111/j.1752-0606.2002.tb01168.x

Stith, S. M., Rosen, K. H., & McCollum, E. E. (2003). Effectiveness of couples treatment for spouse abuse. *Journal of Marital and Family Therapy, 29*(3), 407–426. https://doi.org/10.1111/j.1752-0606.2003.tb01215.x

Stith, S. M., Rosen, K. H., McCollum, E. E., & Thomsen, C. J. (2004). Treating intimate partner violence within intact couple relationships: Outcomes of multi-couple versus individual couple therapy. *Journal of Marital and Family Therapy, 30*(3), 305–318. https://doi.org/10.1111/j.1752-0606.2004.tb01242.x

Thackeray, J., Stelzner, S., Downs, S., & Miller, C. (2007). Screening for intimate partner violence: The impact of screener and screening environment on victim comfort. *Journal of Interpersonal Violence, 22*(6), 659–670. https://doi.org/10.1177/0886260507300206

Todahl, J., & Walters, E. (2009). Universal screening and assessment for intimate partner violence: The IPV screen and assessment tier (IPV-SAT) model. *Journal of Feminist Family Therapy, 21*(4), 247–270. https://doi.org/10.1080/08952830903346022

Todahl, J., & Walters, E. (2011). Universal screening for intimate partner violence: A systematic review. *Journal of Marital and Family Therapy, 37*(3), 355–369. https://doi.org/10.1111/j.1752-0606.2009.00179.x

Trabold, N., McMahon, J., Alsobrooks, S., Whitney, S., & Mittal, M. (2018). A systematic review of intimate partner violence interventions: State of the field and implications for practitioners. *Trauma, Violence, & Abuse, 21*(2), 311–325. https://doi.org/10.1177/1524838018767934

Tran, A., Lin, L., Nehl, E. J., Talley, C. L., Dunkle, K. L., & Wong, F. Y. (2014). Prevalence of substance use and intimate partner violence in a sample of A/PI MSM. *Journal of Interpersonal Violence, 29*(11), 2054–2067. https://doi.org/10.1177/0886260513516006

Vaughan, M. D., & Rodriguez, E. M. (2014). LGBT strengths: Incorporating positive psychology into theory, research, training, and practice. *Psychology of Sexual Orientation and Gender Diversity, 1*(4), 325–334. https://doi.org/10.1037/sgd0000053

Walker, L. (1979). *The battered woman.* Harper & Row.

Weisz, A., Tolman, R. M., & Saunders, D. (2000). Assessing risk of severe domestic violence. *Journal of Interpersonal Violence, 15*(1), 75–90. https://doi.org/10.1177/088626000015001006

Wernick, L. J., Kulick, A., & Chin, M. (2017). Gender identity disparities in bathroom safety and wellbeing among high school students. *Journal of Youth and Adolescence, 6*(5), 917–930. https://doi.org/10.1007/s10964-017-0652-1

Whitton, S. W., Newcomb, M. E., Messinger, A. M., Byck, G., & Mustanski, B. (2016). A longitudinal study of IPV victimization among sexual minority youth. *Journal of Interpersonal Violence, 34*(5), 912–945. https://doi.org/10.1177/0886260516646093

Williams, J. K., Wilton, L., Magnus, M., Wang, L., Wang, J., Dyer, T., Koblin, B. A., Hucks-Ortiz, C., Fields, S. D., Shoptaw, S., Stephenson, R. B., O'Cleirigh, C., & Cummings, V. (2015). Relation of childhood sexual abuse, intimate partner violence, and depression to risk factors for HIV among Black men who have sex with men in 6 US cities. *American Journal of Public Health, 105*(12), 2473–2481. https://doi.org/10.2105/AJPH.2015.302878

Yerke, A. F., & DeFeo, J. (2016). Redefining intimate partner violence beyond the binary to include transgender people. *Journal of Family Violence, 31*(8), 975–979. https://doi.org/10.1007/s10896-016-9887-y

21
Treating LGBT Couples Experiencing Substance Use Disorders

Trauma-Informed and Affirmative Therapy Approaches

MICHAEL SHELTON

Substance Use in the LGBT Community

The U.S. Department of Health and Human Services (2008) defines a *health disparity* as:

> A particular type of health difference that is closely linked with social or economic disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social or economic obstacles to health based on their racial or ethnic group, religion, socioeconomic status, gender, mental health, cognitive, sensory, or physical disability, sexual orientation, geographic location, or other characteristics historically linked to discrimination or exclusion.
>
> *(p. 28)*

Health disparities are noted in substance use disorders (SUDs), including prevalence, etiological factors, and treatment outcomes. Our understanding of the reasons for these noted health disparities is truly in its infancy. An apt illustration of this is a conclusion by Chartier and Caetano (2010), who determined that alcohol research in the United States paid fragmented attention to the implications of race and ethnicity prior to 1984. It was only in 1984 that the first national alcohol survey including Black and Hispanic people—at that time already the two largest ethnic minority groups in the U.S. population—was conducted. Likewise, we are similarly learning more about health disparities experienced by the LGBT population.

The decades following the removal of homosexuality from the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) in 1973 saw a flourishing of research on this demographic, which had until then focused on delineating its causes and "curing" or treating same-sex desire and attraction. Priorities that would have been unthinkable a few years earlier became the norm, including efforts at promoting the mental health of gay men and lesbians, assisting them to navigate a coming out process, overcoming their internalized homophobia, and the creation of gay-affirmative therapies (Grey et al., 2013). Research into the substance use behaviors and patterns of gay men and lesbians soon followed, although studies of substance use by bisexual and transgender individuals would not occur in earnest for another two decades (Hughes & Eliason, 2002). In 2001 the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment released *A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals*, the first federal document on LGBT substance use; it reviewed and summarized available research from the 1970s through the 1990s. It concluded that "LGBT people are more likely to use alcohol and drugs, have higher rates of substance abuse, are less likely to abstain from use, and are more likely to continue heavy drinking into later life" (p. xiii).

DOI: 10.4324/9780429274626-26

During the intervening years, study methodology became more rigorous, meta-analyses of existing studies were conducted, and several large-scale national probability surveys included questions about substance use and sexual orientation and gender identity, thus offering a better understanding of substance use by LGBT individuals. This new era of research was summarized in the Institute of Medicine's report *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* (National Academies Press, 2011), which concluded the following:

- LGB adults might have higher rates of smoking, alcohol use, and substance use than heterosexual adults.
- At the time of the publication, there was very limited research on trans individuals, and that which did exist indicated substance use is a concern for this population.
- Rates of smoking, alcohol consumption, and substance use may be higher among LGB youth than heterosexual youth.

Studies and meta-analyses since the release of this document continue to find that in comparison to heterosexuals and cisgender individuals, LGBT individuals demonstrate elevated rates of SUDs and that there is variability in patterns of substance use by sexual orientation, gender, age, and race/ethnicity.

- Alcohol, cannabis, illicit drugs, and recreational use of prescription drugs are noted as problematic for the transgender population.
- Substance use patterns for bisexual males are mixed in the literature. However, there is consistency regarding bisexual females—they are more likely to report alcohol and drug use in comparison to heterosexuals and gay men.
- Recreational alcohol and cannabis use are common among lesbians. Lesbians demonstrate a smaller decline (or none at all) in alcohol use in contrast to heterosexual females, who typically reduce or end their alcohol use as they age.
- Recreational alcohol and cannabis use are common among gay men. Also, club drugs and methamphetamine are particularly problematic for a subset of gay men.

The above are general conclusions, and population-specific studies offer more insight into the intersection of multiple identities and substance use; these are explored in the section on preliminary treatment considerations.

The Reasons for LGBT Substance Use Health Disparities

According to the National Institute on Drug Abuse (NIDA, 2007), there are four primary reasons individuals initiate substance use. Whether one is heterosexual, gay or lesbian, bisexual, trans- or cisgender, these four reasons predominate:

- **To feel good.** Most abused drugs produce intense feelings of pleasure. Depending on the drug, users can feel euphoric, more powerful, self-confident, relaxed, or energetic.
- **To feel better.** Drug use can reduce stress, anxiety, chronic pain, embarrassment, and shame.
- **Peer pressure and "because others are doing it."**
- **To do better.** Substances can enhance cognitive and performance skills.

Why can some individuals use intoxicating substances without progressing into problematic use or an outright SUD? There is no single definitive answer to this question, but it is clear that progression to a substance use problem is based on a complex interaction among the characteristics of the specific drugs themselves and their route of administration (i.e., oral, inhalation, ingestion, snorting), an individual's biology, genes, age, and the environment. However,

for LGBT people, superimposed on these risk factors is a specific set of challenges unknown to many heterosexual and cisgender individuals.

Minority Stress Meyer (2003) defines minority stress as

> the excess stress to which individuals from stigmatized social categories are exposed as a result of their social, often a minority, position… [M]inority stress is additive to general stressors that are experienced by all people, and therefore, stigmatized people require an adaptation effort above that required of similar others who are not stigmatized.
>
> *(pp. 675–676)*

All humans experience stressors on a daily basis, but minority groups (including LGBT individuals) experience a surfeit of additional stressors that could affect mental health and psychological functioning. In addition, Meyer reports that minority stress is both chronic and socially based—in other words, stemming from institutions, social interactions, and society in general.

Meyer identified three concurrent and converging forms of minority stress: experiencing prejudicial treatment (including risk of violence), internalization of societal rejection and prejudices, and expectations of stigma. Several recent studies support the impact of these stressors on LGBT substance use patterns. For example, in a study of 824 LGB individuals, Weber (2008) found that participants who were classified as having at least one alcohol or drug use disorder were significantly more likely to have experienced heterosexism and internalized homophobia than those who did not have a SUD. McCabe and colleagues (2010) analyzed data from the longitudinal National Epidemiologic Survey on Alcohol and Related Conditions to determine the association between discrimination and substance use. They determined that two-thirds of LGB respondents reported at least one of three forms of discrimination (sexual orientation, gender, and race) during their lifetime. The researchers concluded that the odds of past-year SUDs were nearly four times greater among LGB adults who reported all three types of discrimination prior to the past year than for LGB adults who did not report discrimination. In addition, nearly half of LGB adults who reported discrimination on the basis of gender, race/ethnicity, and sexual orientation in their lifetimes met the criteria for past-year SUDs compared with less than one in five for those who reported no discrimination. Finally, a 2013 meta-analysis determined internalized heterosexism impacts HIV risk behavior, is positively associated with alcohol abuse and dependency, and negatively affects mental health and the quality of intimate relationships (Grey et al., 2013).

The Coming Out Process The coming out process postulates that LGBT individuals pass through specific stages in which designated developmental tasks must be accomplished. Those LGBT individuals successfully passing through these stages experience stable identity and positive psychological development; those who did not risk delayed (and possibly forestalled) identity development and mental-health consequences (Eliason & Schope, 2007). Ethnicity and race also impact the coming out process. One review discerned that Black men experience higher levels of internalized minority stress, are less likely to disclose their sexual orientation, and are more likely to perceive disapproval of same-sex behavior in their communities (Peterson & Jones, 2009). Nearly half of the respondents to a survey of participants at Black gay pride events in the United States stated that racism is a problem in the LGBT community and poses obstacles to coming out (Battle et al., 2002). According to the General Social Survey, relative to white men and women, Latinos/as and those in other racial/ethnic categories are 21 and 18 times (respectively) more likely to have never told anyone about their same-sex sexual behavior or LGB identity (Gates, 2010).

Several hypotheses have been offered regarding substance use and the coming out process. First, LGBT individuals might use one or more substances to self-medicate or to cope with the anxiety and stress inherent in the process, particularly because coming out leads to more frequent encounters with minority stress, traumatizing events, and/or social isolation (Hatzenbuehler, 2009). Several studies find that LGBT youth are more likely to be sexually and physically abused than their heterosexual and gender-conforming peers during their coming out process (Saewyc et al., 2006). Coming out can also lead to family rejection. Ryan et al. (2009) found that in comparison to peers that reported no or low levels of family rejection, LGBT young adults who reported high levels of family rejection as adolescents were 3.4 times more likely to use illegal drugs. Finally, while associating with other LGBT individuals during the coming out process is most often a positive experience, it might lead to engagement with sexual and gender minorities using one or more substances. Rosario et al. (2004), for example, found that involvement in gay-related (recreational and social) activities during the coming out process was associated with increased alcohol and cannabis use.

Bars and Clubs The role of bars and clubs in the lives of LGBT individuals was noted even in early studies, and they offer significant benefits to patrons, including a welcoming environment, a safe space, the opportunity to create and foster relationships, and an environment in which to reduce stress (Leibel et al., 2011). However, frequent use of these venues also leads some LGBT people to believe that alcohol and tobacco use is the norm and to adopt similar alcohol- and tobacco-use practices (Parks, 1999; Remafedi, 2007). Using a large sample of LGB young adults and their heterosexual peers, Hatzenbuehler et al. (2008) found that LGB participants have greater positive expectancies for alcohol (e.g., reducing negative affect, enhancing social experiences, inducing euphoria) than heterosexual participants. Studies also find LGBT individuals report more exposure to alcohol and tobacco industry marketing (Dilley et al., 2008).

The Impact of Substance Use on Couples

LGBT couples struggling with substance use experience the same constellation of repercussions that occur with heterosexual and cisgender couples. Historically, research on substance use in couples highlighted three areas. First, many studies describe the effects of substance use on couples, such as financial problems and increased risk of relationship violence. Second, research, typically in the family therapy field, examines family systems dynamics affected by substance use, such as norms, roles, and boundaries. Finally, process models were developed to explain how couples cope with this mental health condition that often progressively worsens. A SUD can manifest in many guises. A couple's once-shared recreational substance use—such as alcohol or cannabis—may slowly evolve into one member's use becoming problematic while the other's remains static or even decreases. One partner may hide their substance use early in a romantic relationship and only later reveal the true extent of it. Even couples who were abstinent from intoxicating substances throughout their lives may be shocked to find a SUD developing in their elder years. Finally, a person may stop their problematic substance use and remain abstinent for years to decades only to relapse.

Family Repercussions Substance use has emotional, psychological, physical, and financial ramification for families. Whether the substance user is a parent, child, or spouse, common responses to escalating alcohol and/or drug use include arguing and fighting, poor communication, negativity, empty threats and ultimatums (e.g., "I'm leaving you if you don't stop"), efforts to control the environment, digging up "evidence" of drug use with which to confront the user, verbal and physical abuse, financial hardship, and frequent crises. Orford and colleagues (2010)

reviewed two decades of studies from across the globe on the impact of substance use on families. They determined that regardless of culture, common consequences were:

- Living with a family member who is drinking or taking drugs is highly stressful.
- Family members experience worry.
- The relationship becomes disagreeable and sometime aggressive.
- There is conflict over money and possessions.
- The family experiences uncertainty.
- Family life is undermined.

Changing Family Dynamics Escalating substance use insidiously impacts underlying family dynamics, particularly impacting the non-using members' behaviors in order to maintain homeostasis, often by sacrificing their needs, compensating for the increasing negligence of the substance user, and hiding their true feelings (Hook, 2012). Due to the escalating negativity occurring in their interactions, partners in a couple become increasingly estranged from each other; they develop rigid and disengaged boundaries. Also, longstanding rituals may be interrupted or outright end.

Adjustment to a Progressive Mental Health Condition One final focus of research is the process that families go through as a loved one's substance use progresses. Family members often confront an addicted loved one late in the process, and then only after great hesitation and reluctance (DuPont, 1997). Washousky et al. (1993) delineate four stages occurring for addicted families. In the *denial* stage, family members justify, rationalize, and minimize substance use; it is, they believe, "just a phase." In the second stage, *home treatment*, family members reluctantly acknowledge that a problem exists and respond with concerted efforts to elicit the user to stop or at least cut down; they cajole, plead, and offer suggestions and incentives for the user to stop. During the third stage, *chaos*, substance use impacts the family on many levels; the qualities noted in the beginning of this section are occurring. Finally, in the *control* stage, divorce, separation, or emotional estrangement occurs.

Orford et al. (2010) also describe three broad ways in which families cope with substance use. The first approach, *putting up with it*, finds family members resigned to substance use, acceptance, and/or continued self-sacrifice. Older models would label these responses as co-dependent or enabling; more recent models acknowledge that highly stressful circumstances dictate they may be the only feasible response available at the time. The second approach, *withdrawing and gaining independence*, consists of actions such as detachment, separation, or making efforts to improve one's quality of life regardless of the substance user's behaviors. The final approach, *standing up to it*, finds family members actively making efforts to protect the family as well as mandating change through means such as assertiveness, confrontation, and refusal and resistance.

The next section includes a description of a couple experiencing a SUD and who are referred to throughout the remainder of the chapter as the two women engage in the treatment process.

Case Example: Maria and Lynnette

Maria (a 38-year-old white female) and Lynnette (a 42-year-old African American female) have been a couple for 11 years. On a typical Saturday night once a month they drive more than 40 miles from their conservative small town in the Midwest to reach the nearest gay and lesbian bar. Although they wish their local community could be more inclusive, they love their home, neighbors, and particularly the nearness of family. Both enjoy alcohol, but while Maria has a

glass of wine after work, Lynette often drinks to the point of inebriation several times a week. Weekends are particularly problematic since Lynnette often drinks the entire weekend. While this concerns Maria, Lynnette dismisses this anxiety and, on occasion, even hides her alcohol use to avoid an argument. There is no doubt her alcohol use has increased. Recently, Lynnette was in an auto accident after returning from a work function while intoxicated; although there were no injuries, the car itself was severely damaged. Maria demands Lynnette seek help or else risk ending their relationship. Maria has always considered herself as lesbian, but Lynnette's relationship history has primarily been with males.

A perusal of the Internet locates the nearest treatment facility with LGBT experience as 80 miles away, and now with only one car between the couple this is an impossibility. There is one mental health provider in her town, and there is no staff member who specializes in substance abuse. Also, there is no evidence that the facility welcomes LGBT individuals. Finally, the receptionist in the facility attends church with her mother, and Lynnette worries about confidentiality.

Maria and Lynnette finally locate a treatment provider, Carolyn, in another county who has experience with substance use and couples' work (though not necessarily in combination) but does not mention LGBT expertise on her website. Lynnette determines she will have to hide her sexual orientation during the treatment process, while Maria refuses to agree to this stipulation. Both women are confused as to what the treatment process will entail and if this will include couple's work.[1]

Obstacles to Treatment

As the above vignette notes, one of the first challenges confronting Lynnette and Maria is finding a substance use treatment provider who is also culturally component to work with LGBT individuals. A 2013 study by McCabe et al., using a large national sample, determined that many sexual minority members who need substance use treatment do not receive it, and, for those who do, the quality of the treatment may be inadequate. Fifty-seven percent noted that being a sexual minority negatively impacted their treatment experiences. Four themes emerged: clients (a) experienced homophobia from heterosexual clients; (b) found it difficult to be honest and open about gay/bisexual issues; (c) felt vulnerable and unsafe; and (d) felt alienated and not understood. Several participants also reported feeling unsupported by staff. As a result, gay/bisexual respondents were significantly less likely to have completed treatment and more likely to have left treatment due to their needs not being met.

While research on the experiences of LGB individuals in substance-abuse treatment is inarguably limited, it is almost non-existent for transgender individuals. Senreich (2011) interviewed 11 transgender individuals about their experiences in treatment and found the majority expressed negativity about their treatment experiences. Themes included unsafe treatment milieus, unwelcoming staff, and disrespectful treatment by other clients. Lyons et al. (2015) found similar themes but also described incidents of discrimination, rejection, lack of support, and denial of services. Study participants also reported feeling as if their presence was a disturbance to others in treatment.

How available are LGBT-specific or, at the least, LGBT-sensitive programs? In 2007, Cochran et al. found only 62 substance use treatment facilities with specialized LGBT programming, and almost half of these agencies were in New York or California. SAMHSA's (2014a) National Survey of Substance Abuse Treatment Services reiterated this dearth of LGBT-specific programming; it found that only 12% of treatment facilities had specialized programming for LGBT individuals.

A final challenge is the availability of couples counseling for SUDs. There is a paucity of providers in the field using a couple's approach to treating substance use regardless of the patient's

[1] Case study adapted from Michael Shelton, *Fundamentals of LGBT Substance Use Disorders* (New York: Harrington Park Press, 2017), 268.

sexual orientation and/or gender identity. SAMHSA (2004) concludes that couple's therapy is successful for a SUD but acknowledges that treatment facilities and providers typically do not offer a comprehensive family approach to addiction treatment and instead limit their interventions to psychoeducation, typically consisting of teaching families about substance abuse, related behaviors, and the behavioral, medical, and psychological consequences of use.

Preliminary Treatment Considerations

Carolyn, the rural treatment provider chosen by Maria and Lynnette, is very familiar with SUDs; these are all too common in rural areas (Substance Abuse and Mental Health Services Administration, 2014b). Her experience with LGBT couples, in contrast, is non-existent. How will treatment be similar and different for a same-sex couple?

Assessment

One similarity is a thorough assessment, a process for defining the nature of a problem, determining a diagnosis, and developing specific treatment recommendations. This will include an assessment of the impact of substance use on the couple. The Addiction Severity Index (ASI; McLellan et al., 1980), one of the most researched assessments in the field, evaluates the impact of substance use on medical status, employment status, legal status family/social status, and mental health. Assessment helps providers to determine the multiple needs a client might have to address in treatment. For example, Cochran and Cauce (2006) found that 48% of their sample of LGBT clients receiving substance-abuse treatment reported additional mental-health concerns, 53% had current legal involvement (e.g., probation/parole, drug court), and 4.4% were current victims of domestic violence. Finally, and of no minor importance, assessment is the basis for a formal diagnosis of a SUD of a mild, moderate, or severe nature based on the number of presenting symptoms.

An LGBT-nuanced assessment for an LGBT individual will additionally examine the risk factors noted earlier in this chapter, including minority stress, internalized heterosexism, the coming out process, and use of bars and clubs as primary social outlets. Providers should not assume these factors played a role in the development of a SUD, but only a thorough assessment can lead to this determination.

Transgender Individuals For trans individuals, the impact of societal stigmatization needs to be assessed. The American Psychological Association's Task Force on Gender Identity and Gender Variance (2009) concluded, "[S]tigma is a significant factor that negatively impacts transgender people's mental health" (p. 3). Indicative of this stigmatization is the amount of violence experienced by trans individuals. A 2014 report by the National Coalition of Anti-Violence Programs (NCAVP), a collaborative effort among organizations tracking, preventing, and responding to violence against LGBT people, determined that trans individuals are more likely to experience threats, harassment, and intimidation than LGB people. They are also more likely to experience sexual violence. The report concludes, "trans women face an alarming vulnerability to hate violence" (p. 36). The effects of discrimination and harassment appear to be cumulative, and Grant et al. (2011) found 23% of study participants experienced "catastrophic" levels of discrimination; trans people of color are repeatedly found to experience the most harsh treatment. Reback and Fletcher (2014) determined that alcohol use was the most frequently reported substance used by trans women followed by cannabis (25.6%) and methamphetamine (21.5%). A 2005 study of transpeople of color found that almost half of the sample engaged in substance use, and of those only half had sought treatment (Xavier et al., 2005).

Lesbian Women For lesbians, alcohol and cannabis use patterns need to be highlighted. A well-received 2012 review of research on LGBT substance abuse found that while drug abuse is a

concern for the gay male population, the problematic use of alcohol within the lesbian population far surpasses that of drug use (Green & Feinstein, 2012). A 2013 study by McCabe et al., using a large national sample of adults in the United States, found that lesbians had more than three times greater odds of lifetime alcohol use disorder and of any lifetime SUD than did heterosexual women.

The majority of studies on lesbians' substance use do not include sufficient numbers of older women and women of color to permit comparative analysis. One notable exception was the Chicago Health and Life Experiences of Women Study (CHLEW), a four-year longitudinal study of a large and diverse sample of women who self-identify as lesbian, in which Hughes et al. (2006) examined the drinking patterns of its participants. Less than half of the respondents (48%) were non-Hispanic white, 28% were non-Hispanic Black, and 20% were Hispanic/Latina. The "other" group consisted of women who identified as Asian/Pacific Islander, American Indian, or biracial or multiracial. It was found that in contrast to general population surveys of women's drinking in which rates of drinking tend to decrease with age, there were relatively few differences in drinking rates across four age groups of CHLEW respondents. Similarly, there were few age differences in reports of lifetime problem drinking indicators. With regard to racial/ethnic differences, few were found. Parks and Hughes (2005) also used a sample of which only one-half was white. This study also found few differences in levels of alcohol use or drinking-related problems across race/ethnic groups.

Bisexual Individuals For bisexual individuals, the influence of invisibility and double discrimination must be examined. According to *Bisexuality Invisibility: Impact and Recommendations*, the first-ever document released by a U.S. governmental agency examining bisexuality, "Bisexuals experience high rates of being ignored, discriminated against, demonized, or rendered invisible by both the heterosexual world and the lesbian and gay communities" (San Francisco Human Rights Commission, 2011, p. 1). This is echoed in an article in the *Journal of Bisexuality*, "Bisexual women still experience rejection within lesbian communities, and bisexual men are still told that they are lying or in denial" (Bradford, 2011, p. 511). Finally, there are numerous myths about bisexuality that can influence the coming out process such as their sexuality doesn't exist, bisexuality is just a phase, and they are seeking attention and/or are hypersexual.

Research on the intersection of bisexuality and additional identities, such as race, is almost nonexistent other than for gender. While substance use patterns for bisexual males are mixed in the literature, there is consistency regarding bisexual females—they are more likely to report alcohol and drug use in comparison to heterosexuals and gay men. One study concluded that bisexual females have higher prevalence rates of suicidal intent, mental-health difficulties, and use of mental-health services. The authors of the study conjectured that the combination of heterosexism and sexism compound the minority stress experience by females (Mathy et al., 2004). Another study using data from a national population-based study in the United States found very high rates of *DSM*-IV mood and anxiety disorders among bisexual women and lesbians, although bisexual women had the highest rates of almost all disorders. Across nine different mood and anxiety disorders, bisexual women had the highest prevalence rates for seven of nine disorders (Bostwick et al., 2010).

Gay and Bisexual Males For gay and bisexual males, in particular, it is important to evaluate the impact of substance use on sexual behavior. Men who have sex with men continue to be at highest risk for HIV transmission due in large part to high-risk sexual practices combined with substance use. For example, Celentano et al. (2006), in a study of 3,492 young men who have sex with other men, found that half reported not using condoms during sex. Unprotected anal sex was associated with being under the influence of alcohol, amphetamines, marijuana, and/or cocaine. A poll of the substance abuse habits of 1,000 gay men found that two-thirds of them reported having sex while under the influence of a recreational drug (Gay Times, 2014).

The top five drugs used for sexual purposes in descending order were poppers (56%), cannabis (48%), cocaine (41%), MDMA/Ecstasy (40%), and Viagra (32%). Some gay men use substances to enhance sexual pleasure and performance, and certain substances have become enshrined in the gay male community for these effects. For some gay men, any attempts to engage in or enjoy sexual activity are stymied in the absence of the substance. That is, sex without substance use is bland.

Subgroups of men who have sex with men (MSM) have different risk factors and drug use patterns. Older gay men are more likely to have alcohol-related issues while younger gay men engage in stimulant use during circuit parties. Kelly and Parsons (2010) examined non-medical use of prescription medications and found that recreational use of prescription medications occurred primarily with white MSM, HIV-positive MSM, gay-identified MSM, and MSM over 40. Older men were more likely to use erectile dysfunction medications recreationally, while younger MSM were more likely to have used prescription stimulants. In addition to age, race has received some attention in the research. Relative to white sexual-minority men, Black sexual-minority men evidence generally lower risk for illicit drug use. A 2006 review of the literature of risk factors for HIV infection by Millett et al. found that Black MSM were no more likely than other MSM to report drug or alcohol use other than crack cocaine. In a meta-analysis by Millett and colleagues (2007), Blacks were significantly less likely than whites to report any substance use across studies and significantly less likely than white MSM to report any substance use during their lifetime. However, more recent studies indicate that methamphetamine use is rapidly expanding in the Black MSM community (e.g., Halkitis & Jerome, 2008; Solomon et al., 2012).

Withdrawal Management

Another preliminary consideration for a treatment provider is the need for withdrawal management, often called "detoxification," which includes interventions aimed at managing the physical and emotional symptoms that occur after a person stops using a substance. Withdrawal symptoms vary in intensity and duration based on the substance(s) used, the duration and amount of use, and the overall health of the individual. Some substances, such as alcohol, opioids, sedatives, and tranquilizers, produce significant physical withdrawal effects, even seizures. Withdrawal management can occur in numerous settings, including outpatient; Lynnette, in our example, would best be served by having withdrawal supervised by a medical team, which could include hospitalization, due to a risk of physical symptoms stemming from alcohol use. Most periods of withdrawal are relatively short (three to five days) and are managed with medications combined with vitamins, exercise, and sleep. Stabilization is considered a first step toward recovery, but by itself it is not an effective treatment for a SUD.

Level of Care

A provider must also consider the level of care. Studies repeatedly find that the overwhelming majority of individuals with a SUD do not receive treatment and those that do are often placed in a level of care that does not meet their needs. In response, the American Society of Addiction Medicine (ASAM, 2013) formulated a continuum of care in which substance-using clients enter treatment at a level appropriate to their needs and then step up to more intense treatment or down to less intense treatment as needed. Each progressive level of care necessitates more frequent contact between a client and a provider. ASAM criteria are an effort to match a patient's needs to intensity of treatment. Non-residential options are *outpatient* (less than nine hours of therapeutic involvement per week),*intensive outpatient* (9–19 hours of services), and *partial hospitalization* (20 or more hours of services per week). These three options are followed by residential programming of increasing intensity, beginning with those offering primarily recovery

support services to, at the highest level, 24-hour medical management by nurses and physicians. Patients requiring this level of care present with behavioral and cognitive problems are so severe that they require primary medical and nursing care.

Deception

A final consideration is the commonplace behaviors of lying and deception demonstrated by those with a substance use behavior. We see this in the scenario of Lynnette and her efforts to obfuscate the amount of substance use through deception. Many clients enter treatment with ambivalence and reluctance about abstinence. Many find a way to disguise substance use while in treatment, and reliance on self-report does not necessarily offer an accurate picture of substance use occurring while in treatment. Drug testing is thus recommended. Treatment facilities likely already have drug testing protocols in place, typically urinalysis. It is now possible for clients to purchase home drug testing kits at most pharmacies, but these are expensive and easily tampered with, such as submitting a false sample. Many in the field thus have couples collaborate on a system in which the abstinent member monitors a partner by weekly or bi-weekly home administration of a urinalysis. Another option is outpatient labs, which charge for collecting and testing samples.

Case Study Continued

Carolyn engages in a comprehensive assessment of Lynnette, and Maria attends these sessions to collaborate on the former's self-reporting. Her initial DSM-5 diagnosis is Alcohol Use Disorder, Moderate based on the presence of four symptoms, including taking the substance in larger amounts than meant to; continuing to use, even when it causes problems in relationships; tolerance; and spending a lot of time recovering from use of the substance. They agree that Lynnette will contact her primary care provider to disclose her alcohol use and to ask for an opinion as to whether there is need for withdrawal management services. Also, outpatient couples' sessions occurring once per week are scheduled. Carolyn would like to see the couple twice per week but recognizes that distance, transportation, and the couple's employment schedule will prevent this. She describes other options such as intensive outpatient, but acknowledges that there are none even remotely near their hometown. Maria and Lynnette agree that an increase in the level of care will occur if the SUD increases in severity. They also agree that Lynnette will obtain a weekly urinalysis at her physician's to verify abstinence; Carolyn cautions that she cannot work with her unless she has evidence of progress other than self-report. Lynnette, in turn, expresses ambivalence about abstinence, particularly the prospect of life-long abstinence.

Treatment Approaches

The recommended treatment protocol for a couple in which one or more partners is engaging in substance use consists of therapy (individual, couples, or both) and/or 12-Step or other self-help group involvement. The National Institute on Drug Abuse (2012) promotes three goals for substance use treatment. First, a person stops using substances of abuse. Second, individuals return to productivity in the multiple domains of their lives, such as family, work, or school. Third, the individual then remains drug free. A couple's approach supports these goals via improved relationship functioning. Finally, 12-Step programs help recovering individuals develop a sober social support network, teach skills needed to recover, and help patients to take responsibility for their own recovery.

Substance Use Disorder Treatment

Current substance use counseling consists of cognitive behavioral approaches such as addressing a patient's motivation to change, providing incentives for abstinence, building skills to resist drug use, replacing drug using activities with constructive and rewarding activities, improving problem-solving skills, and facilitating better interpersonal relationships. Medication-assisted treatment options might be considered; several medications are available for assisting individuals addicted to opioids and alcohol, and medications for other classes of substances are currently under investigation. Medications are also available to treat other mental health conditions, such as depression or anxiety, that may be contributing to a person's substance use.

Couples Treatment for a Substance Use Disorder

In regard to couples counseling, the goals are to improve current couple's functioning and support abstinence. Existing treatment models include the Sequential Family Addictions Counseling Model (Juhnke & Hagedorn, 2006), Community Reinforcement and Family Training (CRAFT; Smith & Meyers, 2004), and Behavioral Couples Therapy (BCT; O'Farrell & Fals-Stewart, 2006). The latter model is one of the very few to have included same-sex couples in its development. Fals-Stewart' et al. (2009) determined that both gay and lesbian couples who received BCT reported significantly lower proportions of days of heavy drinking in the year after treatment than couples in which the substance-using patient received individual-based treatment only.

Let it be clear that the treatment considerations and interventions described thus far are applicable to all individuals and couples experiencing a SUD regardless of gender identity, sexual orientation, race, financial status, etc. Carolyn, based on her assessment of Maria and Lynnette, formulates initial treatment goals in collaboration with them. These include ending alcohol use, creating an environment that supports abstinence, managing cravings, and replacing alcohol use with other activities. In regard to couples' issues, Carolyn uses a BCT approach of increasing sober enjoyable time together and decreasing arguments, threats, and ultimatums. The use of medication-assisted therapy with Antabuse or Vivitrol is deferred. A major issue is determining how Maria's substance use will impact Lynnette since the former verbalizes an intention to continue her occasional alcohol use. Lynnette is also advised to partake of a local AA meeting.

Nuanced Treatment Approaches for LGBT Couples

The need for demographic-specific treatment is illustrated most notably in the history of substance abuse interventions for women. Until the 1990s, treatment guidelines for males were misguidedly generalized to females with substance use issues. We now recognize the limitations of this approach and acknowledge that when women's specific needs are addressed from the onset, improved treatment engagement, retention, and outcomes are the result. Some notable differences between male and female substance use patterns are the latter's quicker progression from initial use to the development of health-related problems and higher mortality rates even when using a similar or lesser amount of intoxicating substance, a strikingly high prevalence of sexual traumatization, and a likelihood of being introduced to intoxicating substances by a romantic partner. These findings have led to the creation of gender-specific programming focusing on topics such as pregnancy, shame, violence and trauma, and family concerns (SAMHSA, 2009).

As in the past for SUD treatment of women, we have few LGBT-specific models for substance use treatment, including couples' approaches. In his review of the research, Senreich (2010) located only two studies that involved significant others in LGBT individuals' SUD treatment. He found that those whose significant other was invited to participate in therapy had higher rates of abstinence at the end of treatment, higher program completion rates, greater feelings of satisfaction with treatment, and greater feelings of counselor support than those whose

significant other was not invited. Research on couple's therapy for substance use is almost completely absent for bisexual and transgender adults.

Those demographic-specific programs that do exist target gay, bisexual, and MSM and their risk of HIV transmission. Shoptaw et al. (2005), for example, formulated gay-specific cognitive behavioral therapy (GCBT), which integrates standard CBT concepts and interventions with relevant behavioral and cultural aspects for gay and bisexual men, including scenarios involving gay cultural events and environments (e.g., circuit parties), the use of fictional gay and gay-friendly characters in the intervention sessions, and sexual risk-reduction interventions. The Connect with Pride intervention (Wu et al., 2011) is a seven-session couples therapy approach focused on both substance use and HIV risk reduction, and is tailored specifically to Black GBM who use methamphetamine. The 2GETHER couples-based HIV prevention and relationship education intervention for young same-sex male couples focuses on defining healthy and unhealthy relationship characteristics, teaching effective communication skills, reviewing couples-based sexual health information, and discussing strategies for increasing couples' connectedness. Even though substance use was not targeted in this intervention, a decrease in alcohol consumption occurred between pretest and post-test (Newcomb et al., 2017).

Addison and Coolhart (2015) compiled an exhaustive list of common challenges experienced by LGBT couples; these might need exploration in addition to the motivational augmentation, communication skills building, support enhancement, and relationship enrichment seen in existing couples treatment for SUDs. These include:

- A lack of role models and social supports for healthy, long-lasting queer couples.
- Differences in partners' degree of "outness."
- Cross-cultural relationships in which partners differ in their race, ethnicity, religious background, age group/generation, educational attainment, and/or socioeconomic status.
- The need to negotiate gendered roles and activities because of similar gender role "scripts."
- Parenting concerns.
- The option of non-monogamous relationships, particularly for gay men.

A pertinent consideration is a connection between relationship agreements—that is, whether a couple is monogamous or not—and substance use. Parsons and Starks (2014), for example, found that certain sexual arrangements between gay men are associated with drug use behavior; men in monogamous relationships were less likely to use drugs compared to men in open arrangements. Such an association highlights the utility of incorporating sexual arrangement into investigations of drug use among partnered gay men.

Twelve-Step Groups and LGBT Individuals

A culturally sensitive approach will acknowledge the challenges that could arise with 12-Step or other self-help group involvement, a common recommendation for those with a SUD. Research finds that sexual minorities report benefiting from LGBT-specific self-help groups, including prolonged periods of sobriety, increased positive peer support, and decreases in internalized heterosexism (Kus, 1991; Kus & Latcovich, 1995). However, two common concerns regarding self-help groups are noted in the literature. The first is that many LGBT individuals have ambivalence, perhaps even outright antipathy, toward any form of spiritual practice, an acknowledged and integral component of the 12 Steps. Many sexual minorities have been taught that same-sex sexual attraction/behavior and gender-nonconformity are sins. As a result, they may have distanced themselves from religion long before seeking treatment (Booth, 1995). The second oft-stated dislike by sexual and gender minorities is related to the dynamics that often take place in 12-step meetings. There are meetings exclusively for sexual and gender minorities, who report that such settings are highly

desirable (Kus & Latcovich, 1995). Still, many LGBT substance users may not have easy access to LGBT-specific meetings and they instead find themselves in meetings for the general public, which reflect the communities in which they are situated. Meetings are open to anybody, and people with strong antipathy toward LGBT individuals will no doubt be present in some. Thus, LGBT individuals may find themselves on the receiving end of disrespectful and antipathetic treatment. Lombardi (2007) found that transgender participants in mutual-aid societies reported receiving little support from other group members, experienced verbal abuse, and were not allowed to talk about trans issues; one-third stopped attending because of these concerns.

Case Study Continued

As couple's treatment for Maria and Lynnette progresses, other issues impacting their functioning come to the surface. These include differences in Lynnette and Maria's levels of "outness" and comfort with their sexuality, particularly based on racial upbringing. Also, while they have many friends, they have few lesbian friends. Carolyn surmises that internalized heterosexism is a causal factor. In addition, Maria expresses underlying resentment toward Lynnette's identification as a bisexual, a sexual orientation she does not consider "real." Another concern is Lynnette's reluctance to engage in a 12-step group due to concern people there will know her and share her "secrets."

Since there are no easy solutions to these complex concerns, Carolyn utilizes two recommended frameworks—trauma-informed treatment and affirmative therapy—in her work with the couple and the complications that inevitably arise.

Two General Frameworks for Culturally Sensitive Treatment: Trauma-Informed Treatment and Affirmative Therapy

When considering a nuanced approach to couples counseling for SUDs, two frameworks may be particularly helpful: trauma-informed treatment and affirmative therapy.

Trauma-Informed Treatment

Professionals are advised to utilize a trauma-informed stance when working with LGBT substance using individuals. While many enter treatment with classic symptoms of PTSD, many more will be suffering the consequences of far more insidious traumatization. Trauma does not necessarily have to be caused by a single overpowering event, but can also be precipitated through a series of frequent encounters with threats, such as those encountered by some LGBT individuals throughout their lives (Brown, 2008). Since childhood, LGBT individuals may have been bombarded with messages that same-sex attraction and gender non-conforming behaviors are disgusting, sinful, or indicative of mental problems; these experiences are sufficiently traumatizing in themselves. Sue (2010), a leading researcher on the topic, identifies microaggressions based on ethnicity, gender, and sexuality to be the most rampant and insidious. Microaggressions are "brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative slights and insults toward members of oppressed groups" (Nadal, 2008, p. 23). According to Sue,

> When one realizes the devalued groups in our society not only contend with ordinary stressful life events but must also cope with additional stressors associated with race, gender, and sexual orientation, one can only conclude that they are being asked to endure an inhuman amount of stress.
>
> *(p. 96)*

Unfortunately, trauma issues are often not addressed in treatment. Clients may have histories of trauma, but they often do not recognize the significant effects of trauma in their lives; they do not recognize connections between their trauma histories and their presenting problems or they avoid the topic altogether. On their side, treatment providers may not ask questions that elicit a client's history of trauma, may feel unprepared to address trauma-related issues proactively, or may struggle to address traumatic stress effectively within the constraints of their treatment program, the program's clinical orientation, or their agency's directives (Substance Abuse and Mental Health Services Administration, 2014c). Also, treatment may inadvertently re-traumatize some LGBT clients via treatment procedures and practices reminiscent of specific characteristics of past trauma or abuse, and of strong relevance for some LGBT clients, situating treatment in threatening, intimidating, shaming, and unsafe milieus.

SAMHSA (2014c) supports a trauma-informed approach in working with individuals involved in treatment for substance abuse; it recommends we change the existing paradigm, which asks, "What's wrong with you?" to one that asks, "What has happened to you?" Similarly, Khanna and Madoori (2013) report that trauma-informed care (a) is careful not to re-traumatize; (b) focuses on resilience; (c) focuses on empowerment; (d) prioritizes organizational safety; and (e) may offer trauma-specific treatment that directly addresses the symptoms of trauma (e.g., desensitization).

The need for trauma-informed treatment is most noted in working with bisexual and transgender individuals. Even programs that pride themselves as competent in working with LGBT people often have little expertise with bisexuals, and bisexuals typically receive treatment protocols tailored for lesbians and gay men. As one report summarized, "[S]ervices designed for gay and lesbian people frequently leave bisexual people feeling as though no one quite knows what to do with them" (Coalition for Lesbian and Gay Rights in Ontario, 1997, p. 31). It may be difficult or risky for bisexual clients to come out as bisexual even in a lesbian/gay-affirmative treatment program. Clients may be unwilling to label themselves as bisexual because they fear that counselors will not understand them or their concerns.

Similarly, trans individuals face re-traumatization during treatment. In her examination of the substance-abuse treatment experiences of transgender individuals, Lombardi (2007) concludes that reluctance to engage in treatment is based on past experiences with discriminatory practices in medical care and expectations that the same will occur while in treatment for substance use. Unfortunately, this expectation is too often proven true. For example, the Transgender Substance Abuse Treatment Policy Group of the San Francisco Lesbian, Gay, Bisexual, and Transgender Substance Abuse Task Force (1995) found that those in substance-abuse treatment programs experienced verbal and physical abuse by other clients and staff, were required to wear clothing judged to be appropriate for their biological gender, and were required to sleep in areas appropriate for their biological gender. Lombardi's 2007 study—completed more than a decade after the San Francisco report—determined that these practices still continue.

Affirmative Therapy

Affirmative therapy, according Van Den Bergh and Crisp (2004), does not prescribe a particular method of practice but rather promotes a stance of unconditional positive regard and acceptance of a client that affirms a client's sense of dignity and worth. Affirmative therapy thus is an approach underlying the other therapeutic skills and interventions. Crisp (2006) describes the three bedrock tenets on which affirmative treatment is built. First, sexual and gender minorities must be considered in the context of the many environments in which they interact and their roles within these environments. Second, LGBT individuals have many strengths they can utilize to address presenting issues. Third, practitioners must engage in culturally competent treatment regarding the intersecting identities with which LGBT clients present.

Appleby et al. (1998) describe the principles of an affirmative practice for LGB individuals. In addition to working on one's own possible heterosexist bias and beliefs, the treatment provider:

- Should not assume a client is heterosexual.
- Should acknowledge that societal rejection and heterosexism impacts LGB individuals.
- Should work with clients to decrease internalized heterosexism.
- Should become knowledgeable about the coming out process.
- Should guide the therapeutic process to help an LGB person develop an acceptance of their identity.

Similarly, Hunter et al. (1998) described several guidelines underlying affirmative practice, including valuing a client's sexual orientation, recognizing that sexual orientation is not the problem for an LGB person but that societal heterosexism is, and assisting clients in navigating the coming out process and deciding how "out" they want or need to be.

Although affirmative treatment principles were built on an understanding of LGB individuals, they have also been applied to the transgender population. First, providers must be aware of best practices and standards of care for those subsumed under the transgender appellative. The most recognized are those promulgated by the World Professional Association for Transgender Health, which supports (Coleman et al., 2012):

- Expanding one's view of gender beyond the binary.
- The ability to assess for gender dysphoria.
- Providing information regarding options for gender identity and expression (which may or may not include surgery and/or hormones).
- Assessing, diagnosing, and treating other mental health concerns.
- Addressing the impact of stigma and minority stress on one's mental health and human development.
- Facilitating a coming out process.

Singh et al. (2011) identified several themes that could buttress such a model, including helping clients evolve a self-generated definition of "self" (i.e., transgender individuals should be able to use their own words to describe their gender), helping clients embrace their self-worth, increasing awareness of oppression, assisting clients to connect with a supportive community, and cultivating hope for the future.

Case Study Continued

In her work with Maria and Lynnette, Carolyn uses both trauma-informed and affirmative approaches. Knowing that internalized homophobia is linked to poor relationship quality within both male and female same-sex relationships and that those experiencing higher levels are less likely to make efforts to maintain relationships in the face of partner conflict (Frost & Meyer, 2009), Carolyn introduces the Lesbian Internalized Homophobia Scale (Szymanski & Chung, 2001). Its five dimensions include: (a) the connection with the lesbian community dimension, describing a lesbian's separation from or connection to the larger lesbian community, including how comfortable she feels in social situations involving lesbians or lesbian activities and the importance of having other lesbians as a support network; (b) the public identification as a lesbian dimension, describing how a lesbian manages her identity, ranging from passing and fear of discovery to disclosure of her identity to others; (c) the personal feelings about being a lesbian dimension, describing personal feelings about being a lesbian ranging from self-hatred to self-acceptance; (d) the moral and religious attitudes toward lesbianism dimension, referring to

global attitudes ranging from condemnation to tolerance and acceptance; and (e) the attitudes toward other lesbians dimension, describing attitudes lesbians hold about members of their own group ranging from oppression/hostility to group appreciation. (Note: other instruments such as the revised Internalized Homophobia Scale [Meyer, 1995] appear to be appropriate for use with bisexual individuals, lesbians, and gay men.)

The responses that Lynnette and Maria gave to these queries in a joint session were revealing, and they began to recognize just how different their implicit experiences of being a lesbian were. This led into a discussion of the pivotal life events that shaped these beliefs, including early life experiences of family and peer rejection. Their attempts to model a same-sex relationship on that of their parents' examples were also explored, including the differences between same-sex and heterosexual relationships. The challenges in their differences in level of "outness" were thoroughly processed. Throughout treatment, Carolyn prioritized the importance of avoiding re-traumatization.

For Carolyn, combining trauma-informed treatment and affirmative treatment with existing protocols for substance using females and couples therapy, such as BCT, was indeed as much an art as it was a science. It was also successful in the long run with Maria and Lynnette even though Lynnette never did attend more than a handful of 12-Step groups. Both partners reported a decrease in relationship tension and negativity as well as increased commitment to each other. They successfully problem-solved as to how Maria could continue with alcohol use but in a way as not to trigger Lynnette. Treatment concluded with several sessions focused on relapse prevention planning, an intervention that considers the potential for relapse, how to reduce this risk, and use of treatment re-engagement if needed. The couple also engage in continuing care, in which they meet with Carolyn once a month for check-ins for six months regarding progress and unexpected challenges and obstacles.

Conclusion

Substance use and SUDs are elevated in LGBT populations. While LGBT individuals share many of the same risk factors as heterosexual and cisgender individuals, there are some notable differences, particularly minority stress, the coming out process, the risk of rejection, and violence. LGBT individuals seeking counseling for a SUD, including their partners and families, will likely not engage in treatment in an LGBT-specialized facility; they simply are too few in number. Instead they will engage in treatment and 12-Step meetings in their local communities with providers using models developed for heterosexual and cisgender groups. The evidence that exists, though it is scant, suggests that these models can be successful if nuanced to LGBT experiences and buttressed by cultural competence, affirmative treatment, and a trauma-informed approach.

References

Addison, S. M., & Coolhart, D. (2015). Expanding the therapy paradigm with queer couples: A relational intersectional lens. *Family Process, 54*(3), 435–453. https://doi.org/10.1111/famp.12171

American Society of Addiction Medicine. (2013). *The ASAM criteria* (3rd ed.). The Change Companies.

Appleby, G. A., Anastas, J., & Anastas, J. W. (1998). *Not just a passing phase: Social work with gay, lesbian, and bisexual people*. Columbia University Press.

Battle, J., Cohen, C. J., Warren, D., Fergerson, G., & Audam, S. (2002). *Say it loud I'm Black and I'm proud: Black pride survey 2000*. Policy Institute of the National Gay and Lesbian Task Force.

Booth, L. (1995). Spirituality and the gay community. *Journal of Gay & Lesbian Social Services, 2*(1), 57–66. https://doi.org/10.1300/J041v02n01_06

Bostwick, W. B., Boyd, C. J., Hughes, T. L., & McCabe, S. E. (2010). Dimensions of sexual orientation and the prevalence of mood and anxiety disorders in the United States. *American Journal of Public Health, 100*(3), 468–475. https://doi.org/10.2105/AJPH.2008.152942

Bradford, M. (2011). Reflections on the bisexual experience. *Journal of Bisexuality, 11*(4), 509–512. https://doi.org/10.1080/15299716.2011.620856

Brown, L. S. (2008). *Cultural competence in trauma therapy: Beyond the flashback*. American Psychological Association.

Celentano, D. D., Valleroy, L. A., Sifakis, F., MacKellar, D.A., Hylton, J., Thiede, H., McFarland, W., Shehan, D. A., Stoyanoff, S. R., LaLota, M., & Koblin, B. A. (2006). Associations between substance use and sexual risk among very young men who have sex with men. *Sexually Transmitted Diseases, 33*(4), 265–271. https://doi.org/10.1097/01.olq.0000187207.10992.4e

Center for Substance Abuse Treatment. (2001). *A provider's introduction to substance abuse treatment for lesbian, gay, bisexual, and transgender individuals.* US Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment.

Chartier, K., & Caetano, R. (2010). Ethnicity and health disparities in alcohol research. *Alcohol Research & Health, 33*(1–2), 152.

Coalition for Lesbian and Gay Rights in Ontario. (1997). *Systems failure: A report on the experiences of sexual minorities in Ontario's health-care and social-services systems*. Coalition for Lesbian and Gay Rights in Ontario.

Cochran, B. N., & Cauce, A. M. (2006). Characteristics of lesbian, gay, bisexual, and transgender individuals entering substance abuse treatment. *Journal of Substance Abuse Treatment, 30*(2), 135–146. https://doi.org/10.1016/j.jsat.2005.11.009

Cochran, B. N., Peavy, K. M., & Robohm, J. S. (2007). Do specialized services exist for LGBT individuals seeking treatment for substance misuse? A study of available treatment programs. *Substance Use & Misuse, 42*(1), 161–176. https://doi.org/10.1080/10826080601094207

Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., Fraser, L., Green, J., Knudson, G., Meyer, W. J., & Monstrey, S. (2012). Standards of care for the health of transsexual, transgender, and gender-nonconforming people, version 7. *International Journal of Transgenderism, 13*(4), 165–232. https://www.wpath.org/publications/soc

Crisp, C. (2006). The gay affirmative practice scale (GAP): A new measure for assessing cultural competence with gay and lesbian clients. *Social Work, 51*(2), 115–126. https://doi.org/10.1093/sw/51.2.115

Dilley, J. A., Spigner, C., Boysun, M. J., Dent, C. W., & Pizacani, B. A. (2008). Does tobacco industry marketing excessively impact lesbian, gay and bisexual communities? *Tobacco Control, 17*(6), 385–390. https://doi.org/10.1136/tc.2007.024216

DuPont, R. L. (1997). *The selfish brain: Learning from addiction*. Hazelden Publishing.

Eliason, M. J., & Schope, R. (2007). Shifting sands or solid foundation? Lesbian, gay, bisexual, and transgender identity formations. In I. H. Meyer & M. E. Northridge (Eds.), *The health of sexual minorities* (pp. 3–26). Springer

Fals-Stewart, W., O'Farrell, T. J., & Lam, W. K. (2009). Behavioral couple therapy for gay and lesbian couples with alcohol use disorders. *Journal of Substance Abuse Treatment, 37*(4), 379–387. https://doi.org/10.1016/j.jsat.2009.05.001

Frost, D. M., & Meyer, I. H. (2009). Internalized homophobia and relationship quality among lesbians, gay men, and bisexuals. *Journal of Counseling Psychology, 56*(1), 97–109. https://doi.org/10.1037/a0012844

Gates, G. J. (2010). *Sexual minorities in the 2008 General Social Survey: Coming out and demographic characteristics*. The Williams Institute.

Gay Times. (2014). *Drug survey 2014.* Gay Times.

Grant, J. M., Mottet, L., Tanis, J. E., Harrison, J., Herman, J., & Keisling, M. (2011). *Injustice at every turn: A report of the National Transgender Discrimination Survey.* National Center for Transgender Equality.

Green, K. E., & Feinstein, B. A. (2012). Substance use in lesbian, gay, and bisexual populations: An update on empirical research and implications for treatment. *Psychology of Addictive Behaviors, 26*(2), 265–278. https://doi.org/10.1037/a0025424

Grey, J. A., Robinson, B. B. E., Coleman, E., & Bockting, W. O. (2013). A systematic review of instruments that measure attitudes toward homosexual men. *Journal of Sex Research, 50*(3–4), 329–352. https://doi.org/10.1111/jasp.12140

Halkitis, P. N., & Jerome, R. C. (2008). A comparative analysis of methamphetamine use: Black gay and bisexual men in relation to men of other races. *Addictive Behaviors, 33*(1), 83–93. https://doi.org/10.3109/16066359.2011.552816

Hatzenbuehler, M. L. (2009). How does sexual minority stigma "get under the skin"? A psychological mediation framework. *Psychological Bulletin, 135*(5), 707–730. https://doi.org/10.1037/a0016441

Hatzenbuehler, M. L., Corbin, W. R., & Fromme, K. (2008). Trajectories and determinants of alcohol use among LGB young adults and their heterosexual peers: Results from a prospective study. *Developmental Psychology, 44*(1), 81–90. https://doi.org/10.1037/0012-1649.44.1.81

Hook, M. K. (2012). Alcohol addiction and families. In D. Capuzzi & M. D. Stauffer (Eds.), *Foundations of addictions counseling* (2nd ed., pp. 278–300). Pearson.

Hughes, T. L., & Eliason, M. (2002). Substance use and abuse in lesbian, gay, bisexual and transgender populations. *Journal of Primary Prevention, 22*(3), 263–298. https://doi.org/10.1023/A:1013669705086

Hughes, T. L., Wilsnack, S. C., Szalacha, L. A., Johnson, T., Bostwick, W. B., Seymour, R., Aranda, F., Benson, P., & Kinnison, K. E. (2006). Age and racial/ethnic differences in drinking and drinking-related problems in a community sample of lesbians. *Journal of Studies on Alcohol, 67*(4), 579–590. https://doi.org/10.15288/jsa.2006.67.579

Hunter, S., Shannon, C., Knox, J., & Martin, J. I. (1998). *Lesbian gay, and bisexual youths and adults: Knowledge for human services practice.* Sage.

Juhnke, G. A., & Hagedorn, W. B. (2006). *Counseling addicted families: An integrated assessment and treatment model*. Routledge.

Kelly, B. C., & Parsons, J. T. (2010). Prevalence and predictors of non-medical prescription drug use among men who have sex with men. *Addictive Behaviors, 35*(4), 312–317. https://doi.org/10.1016/j.addbeh.2009.11.002

Khanna, N., & Madoori, S. (2013). Untangling the intersection of HIV & trauma: Why it matters and what we can do. *GMHC Treatment Issues.* https://www.poz.com/pdfs/gmhc_treatmentissues_2013_9.pdf

Kus, R. J. (1991). Sobriety, friends, and gay men. *Archives of Psychiatric Nursing, 5*(3), 171–177. https://doi.org/10.1016/0883-9417(91)90018-Z

Kus, R. J., & Latcovich, M. A. (1995). Special interest groups in Alcoholics Anonymous: A focus on gay men's groups. *Journal of Gay & Lesbian Social Services, 2*(1), 67–82. https://doi.org/10.1300/J041v02n01_07

Leibel, K., Lee, J. G., Goldstein, A. O., & Ranney, L. M. (2011). Barring intervention? Lesbian and gay bars as an underutilized venue for tobacco interventions. *Nicotine & Tobacco Research, 13*(7), 507–511. https://doi.org/10.1093/ntr/ntr065

Lombardi, E. (2007). Substance use treatment experiences of transgender/transsexual men and women. *Journal of LGBT Health Research, 3*(2), 37–47. https://doi.org/10.1300/J463v03n02_05

Lyons, T., Shannon, K., Pierre, L., Small, W., Krüsi, A., & Kerr, T. (2015). A qualitative study of transgender individuals' experiences in residential addiction treatment settings: Stigma and inclusivity. *Substance Abuse Treatment, Prevention, and Policy, 10*(1), 1–6. https://doi.org/10.1186/s13011-015-0015-4

Mathy, R. M., Lehmann, B. A., & Kerr, D. L. (2004). Bisexual and transgender identities in a nonclinical sample of North Americans: Suicidal intent, behavioral difficulties, and mental health treatment. *Journal of Bisexuality, 3*(3–4), 93–109. https://doi.org/10.1300/J159v03n03_07

McCabe, S. E., Bostwick, W. B., Hughes, T. L., West, B. T., & Boyd, C. J. (2010). The relationship between discrimination and substance use disorders among lesbian, gay, and bisexual adults in the United States. *American Journal of Public Health, 100*(10), 1946–1952. https://doi.org/10.2105/AJPH.2009.163147

McCabe, S. E., West, B. T., Hughes, T. L., & Boyd, C. J. (2013). Sexual orientation and substance abuse treatment utilization in the United States: Results from a national survey. *Journal of Substance Abuse Treatment, 44*(1), 4–12. https://doi.org/10.1016/j.jsat.2012.01.007

McLellan, A. T., Luborsky, L., O'Brien, C. P., & Woody, G. E. (1980). An improved diagnostic instrument for substance abuse patients: The Addiction Severity Index. *Journal of Nervous & Mental Diseases, 168*(1), 26–33. https://doi.org/10.1097/00005053-198001000-00006

Meyer, I. H. (1995). Minority stress and mental health in gay men. *Journal of Health and Social Behavior,* 36(1), 38–56. https://doi.org/10.2307/2137286

Meyer, I. H. (2003). Prejudice, social stress, and mental health in lesbian, gay, and bisexual populations: Conceptual issues and research evidence. *Psychological Bulletin, 129*(5), 674–697. https://doi.org/10.1037/2329-0382.1.S.3

Millett, G. A., Flores, S. A., Peterson, J. L., & Bakeman, R. (2007). Explaining disparities in HIV infection among black and white men who have sex with men: A meta-analysis of HIV risk behaviors. *AIDS, 21*(15), 2083–2091. https://doi.org/10.1097/QAD.0b013e3282e9a64b

Millett, G. A., Peterson, J. L., Wolitski, R. J., & Stall, R. (2006). Greater risk for HIV infection of Black men who have sex with men: A critical literature review. *American Journal of Public Health, 96*(6), 1007–1019. https://doi.org/10.2105/AJPH.2005.066720

Nadal, K. L. (2008). Preventing racial, ethnic, gender, sexual minority, disability, and religious microaggressions: Recommendations for promoting positive mental health. *Prevention in Counseling Psychology: Theory, Research, Practice and Training, 2*(1), 22–27.

National Academies Press. (2011). *The health of lesbian, gay, bisexual and transgender people: Building a foundation for better understanding*. National Academies Press.

National Coalition of Anti-Violence Programs. (2014). *Lesbian, gay, bisexual, transgender, queer, and HIV-affected hate violence in 2013.* National Coalition of Anti-Violence Programs.

National Institute on Drug Abuse. (2007). *Science of addiction*. National Institute on Drug Abuse.

National Institute on Drug Abuse. (2012). *Principles of drug abuse treatment*. National Institute on Drug Abuse.

Newcomb, M. E., Macapagal, K. R., Feinstein, B. A., Bettin, E., Swann, G., & Whitton, S. W. (2017). Integrating HIV prevention and relationship education for young same-sex male couples: A pilot trial of the 2GETHER intervention. *AIDS and Behavior, 21*(8), 2464–2478. https://doi.org/10.1007/s10461-017-1674-0

O'Farrell, T. J. & Fals-Stewart, W. (2006). *Behavioral couples therapy for alcoholism and drug abuse.* Guilford.

Orford, J., Velleman, R., Copello, A., Templeton, L., & Ibanga, A. (2010). The experiences of affected family members: A summary of two decades of qualitative research. *Drugs: Education, Prevention and Policy, 17*(sup1), 44–62. https://doi.org/10.3109/09687637.2010.514192

Parks, C. A. (1999). Lesbian social drinking: The role of alcohol in growing up and living as lesbian. *Contemporary Drug Problems, 26*(1), 75–129. https://doi.org/10.1177/009145099902600105

Parks, C. A., & Hughes, T. L. (2005). Alcohol use and alcohol-related problems in self-identified lesbians: An historical cohort analysis. *Journal of Lesbian Studies, 9*(3), 31–44. https://doi.org/10.1300/J155v09n03_04

Parsons, J. T., & Starks, T. J. (2014). Drug use and sexual arrangements among gay couples: Frequency, interdependence, and associations with sexual risk. *Archives of Sexual Behavior, 43*(1), 89–98. https://doi.org/10.1007/s10508-013-0237-3

Peterson, J. L., & Jones, K. T. (2009). HIV prevention for Black men who have sex with men in the United States. *American Journal of Public Health, 99*(6), 976–980. https://doi.org/10.2105/AJPH.2008.143214

Reback, C. J., & Fletcher, J. B. (2014). HIV prevalence, substance use, and sexual risk behaviors among transgender women recruited through outreach. *AIDS and Behavior, 18*(7), 1359–1367. https://doi.org/10.1007/s10461-013-0657-z

Remafedi, G. (2007). Lesbian, gay, bisexual, and transgender youths: Who smokes, and why? *Nicotine & Tobacco Research, 9*(Suppl_1), S65-S71. https://doi.org/10.1080/14622200601083491

Rosario, M., Schrimshaw, E. W., & Hunter, J. (2004). Predictors of substance use over time among gay, lesbian, and bisexual youths: An examination of three hypotheses. *Addictive Behaviors, 29*(8), 1623–1631. https://doi.org/10.1016/j.addbeh.2004.02.032

Ryan, C., Huebner, D., Diaz, R. M., & Sanchez, J. (2009). Family rejection as a predictor of negative health outcomes in white and Latino lesbian, gay, and bisexual young adults. *Pediatrics, 123*(1), 346–352. https://doi.org/10.1542/peds.2007-3524

Saewyc, E. M., Skay, C. L., Pettingell, S. L., Reis, E. A., Bearinger, L., Resnick, M., Murphy, A., & Combs, L. (2006). Hazards of stigma: The sexual and physical abuse of gay, lesbian, and bisexual adolescents in the United States and Canada. *Child Welfare, 85*(2), 195–213. https://doi.org/10.1016/j.jadohealth.2003.11.069

San Francisco Human Rights Commission. (2011). *Bisexuality invisibility: Impact and recommendations*. San Francisco Human Rights Commission.

Senreich, E. (2010). Inviting the significant other of LGBT clients into substance abuse treatment programs: Frequency and impact. *Contemporary Family Therapy, 32*(4), 427–443. https://doi.org/10.1007/s10591-010-9133-3

Senreich, E. (2011). The substance abuse treatment experiences of a small sample of transgender clients. *Journal of Social Work Practice in the Addictions, 11*(3), 295–299. https://doi.org/10.1080/1533256X.2011.592795

Shoptaw, S., Reback, C. J., Peck, J. A., Yang, X., Rotheram-Fuller, E., Larkins, S., Veniegas, R. C., Freese, T. E., & Hucks-Ortiz, C. (2005). Behavioral treatment approaches for methamphetamine dependence and HIV-related sexual risk behaviors among urban gay and bisexual men. *Drug and Alcohol Dependence, 78*(2), 125–134. https://doi.org/10.1016/j.drugalcdep.2004.10.004

Singh, A. A., Hays, D. G., & Watson, L. S. (2011). Strength in the face of adversity: Resilience strategies of transgender individuals. *Journal of Counseling & Development, 89*(1), 20–27. https://doi.org/10.1002/j.1556-6678.2011.tb00057.x

Smith, J. E., & Meyers, R. J. (2004). *Motivating substance users to enter treatment*. Guilford.

Solomon, T. M., Halkitis, P. N., Moeller, R. W., & Pappas, M. K. (2012). Levels of methamphetamine use and addiction among gay, bisexual, and other men who have sex with men. *Addiction Research & Theory, 20*(1), 21–29. https://doi.org/10.3109/16066359.2011.552816

Substance Abuse and Mental Health Services Administration. (2004). *Treatment improvement protocol series, No. 39*: *Substance abuse treatment and family therapy.* Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (2009). *Treatment improvement protocol series, No. 51*: *Substance abuse treatment: Addressing the specific needs of women.* Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (2014a). *National survey of substance abuse treatment services (N-SSATS): 2013. Data on substance abuse treatment facilities.* Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (2014b). *Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings.* Substance Abuse and Mental Health Services Administration.

Substance Abuse and Mental Health Services Administration. (2014c). *Treatment improvement protocol series, No. 57: Trauma-informed care in behavioral health services.* Substance Abuse and Mental Health Services Administration.

Sue, D. W. (2010). *Microaggressions in everyday life: Race, gender, and sexual orientation*. Wiley.

Szymanski, D. M., & Chung, Y. B. (2001). The Lesbian Internalized Homophobia Scale: A rational/theoretical approach. *Journal of Homosexuality, 41*(2), 37–52. https://doi.org/10.1300/J082v41n02_03

Task Force on Gender Identity and Gender Variance. (2009). *Report of the task force on gender identity and gender variance.* American Psychological Association.

The Transgender Substance Abuse Treatment Policy Group. (1995). *Transgender protocol: Treatment service guidelines for substance abuse treatment providers.* Lesbian, Gay, Bisexual, Transgender Substance Abuse Task Force.

U.S. Department of Health and Human Services. (2008). *The Secretary's Advisory Committee on national health promotion and disease prevention objectives for 2020. Phase I report: Recommendations for the framework and format of healthy people 2020.* U.S. Department of Health and Human Services.

Van Den Bergh, N., & Crisp, C. (2004). Defining culturally competent practice with sexual minorities: Implications for social work education and practice. *Journal of Social Work Education, 40*(2), 221–238. https://doi.org/10.1080/10437797.2004.10778491

Washousky, R., Levy-Stern, D., & Muchowski, P. (1993). The stages of family alcoholism. *EAP Digest,* 38–42.

Weber, G. (2008). Using to numb the pain: Substance use and abuse among lesbian, gay, and bisexual individuals. *Journal of Mental Health Counseling, 30*(1), 31–48. https://doi.org/10.17744/mehc.30.1.2585916185422570

Wu, E., El-Bassel, N., McVinney, L. D., Hess, L., Remien, R. H., Charania, M., & Mansergh, G. (2011). Feasibility and promise of a couple-based HIV/STI preventive intervention for methamphetamine-using, Black men who have sex with men. *AIDS and Behavior, 15*(8), 1745–1754. https://doi.org/10.1007/s10461-011-9997-8

Xavier, J. M., Bobbin, M., Singer, B., & Budd, E. (2005). A needs assessment of transgendered people of color living in Washington, DC. *International Journal of Transgenderism, 8*(2–3), 31–47. https://doi.org/10.1300/J485v08n02_04

22
Rewrite the Script
A Call for More Queer and Inclusive Couple Enrichment Programs

SHOSHANA D. KEREWSKY, DARIEN T. COMBS, and NATHAN MATHER

Interviewer: How did you feel during the workshop?

June: I didn't feel like an anomaly other than the fact that we were the youngest couple and the newest couple. We were the only queer couple, as far as we knew. But then again, who are we to say that?

Interviewer: Did you feel like you got out of it as much as everyone else?

Zoe: It was designed for, and led to, a lot of men having realizations about the importance of communication. We were like, yeah, we have that part down.

June: I think we still learned a lot.

Interviewer: If you were leading a retreat like this, what would you change to make it more gender- and sexual identity-inclusive?

Zoe: I would rewrite the script to make sure that the facilitator wouldn't say a sentence about, "Your husband, oh, I mean, 'your partner.'" I would rewrite it so it is gender-neutral to begin with, so the clients don't get the feeling, "Oh, they're just changing that because I'm here." It would be more organically inclusive of everybody, which I think is pretty obvious, but for some reason, doesn't seem to happen a lot.

Introduction and Terminology

From their religion-based origin to contemporary options, few couple enrichment (CE) programs have welcomed queer couples and even fewer are designed to be specific to the needs of queer partnerships. This chapter begins with brief notes on terminology and relevant intersectional identity considerations followed by a review of the literature on CE, describing the structures/components of typical programs and research on CE program outcomes. We then describe social issues and areas of vulnerability and strength relevant to queer people and CE activities. We suggest that much of the CE research to date is flawed as a result of heteronormative and gender-normative assumptions, omission, and elision of bisexual and transgender partners' experiences, and long-term, dyadic relationships as its focus. Few resources exist for queer people seeking relationship enrichment. Fortunately, a small handful of queer-welcoming and population-specific programs are available. We describe several available CE options for queer partners, as well as ways therapists can be helpful. Finally, we note that this chapter is based on U.S. CE programs. Aspects of intersectional identity may contribute to more risk or resilience in other countries and cultures.

Because the literature on this topic spans not only decades but also worldviews, we use the term *couple enrichment* when we refer generally to couples' activities and workshops that include psychoeducation, prevention strategies, skill building, and related activities. We use *queer* as an umbrella term and *lesbian*, *gay*, *bisexual*, *transgender*, and other terms when greater specificity is required. We use *male* and *female* with the understanding that these identities are not binary or exclusive.

DOI: 10.4324/9780429274626-27

> Robert and Diego met at a second-hand bookstore eight years ago in downtown Los Angeles, fell in love, and have been together since. Robert's job at a design company demands long hours, and Diego increasingly has been spending time at local queer bars by himself, often sending angry texts to Robert while drinking. They sought guidance from a couple's therapist. Their therapist thought they could benefit from a couple enrichment retreat to reconnect and redirect their relationship. Because they are a gay Latino couple, the therapist is not sure where to refer them for an affirmative, culturally-informed experience.

Unfortunately, many CE programs accommodate queer people insufficiently or not at all. A similar lack of attention to other identity factors (e.g., ethnicity, migration status, age) that may be relevant to the partners' experiences compounds this deficit. Moreover, some couples appear to be heterosexual or queer, but this may be an incorrect assumption or an oversimplification of the relationship's characteristics. There continues to be a paucity of research on the romantic relationships of transgender individuals, although there has been an increase in this area in the past decade. Most transgender individuals in romantic partnerships have a cisgender partner (Fein et al., 2018). Overall, CE providers should be ready for couples to present in a variety of ways.

Generally speaking, CE and other partner interventions are structured for couples. However, some relationships, both queer and otherwise, are not structured dyadically. Consensual nonmonogamy (CNM) is an umbrella term to describe relationships in which all partners have agreed to engage in extradyadic or multiple sexual or romantic relationships (Conley et al., 2013). One study found that there are no significant differences between monogamous and CNM relationships in terms of relationship satisfaction and sexual satisfaction (Wood et al., 2018). Some therapists hold judgmental or pathologizing views of CNM relationships, lack the basic knowledge of CNM issues to be effective, lack training, and are unprepared to offer appropriate services to CNM-identified individuals (Schechinger et al., 2018). There is convergence and divergence between the CNM and LGBTQ communities; both may experience coming out/visibility management, discrimination, negative internalizations from minority stress, and other stressors (Schechinger et al., 2018).

> Devinae and her partner Tasia looked for CE programs. They found that most programs served heterosexual couples, and that lesbian-focused retreats seemed to serve predominantly white women. Discouraged, they decided that maybe there wasn't a program that would feel safe for them.

Despite increasing awareness of queer identities and the legalization of marriage and other rights for queer couples, many CEs are based on assumptions about, and research on, engaged or married heterosexual dyads. Partners are presumed to have been born in their present or apparent biological gender. Given the increased visibility and acceptance of queer people in the past two decades, it is surprising that more CEs do not clearly include queer couples.

A Brief History of CE Programs

A number of authors have described and reviewed CE programs (e.g., Halford, 2004; Hunt et al., 1998; Jakubowski et al., 2004; Larson, 2007). The present chapter is not exhaustive but includes representative material and examples. Until recently, the literature on this topic has been based on a presumptive male-female, non-queer couple. CE programs evolved from the premarital counseling sessions some religious communities offered to engaged couples (Halford, 2004; Hunt et al., 1998). These sessions approached their present form by 1952, when Fr. Gabriel Calvo, a Spanish Roman Catholic priest, created the "Encuentro Conyugal" (Rest Stop, 1999). This

religious origin still permeates many CE programs explicitly (Halford, 2004), as in the case of Worldwide Marriage Encounter (2018) and the Hope Focused approach (Worthington et al., 2007). It may also be implicit in the values that guide other programs. For example, many writers describe the goal of CE as stabilizing marriages for the sake of children and, ultimately, society (e.g., Hunt et al., 1998). Halford (2004) reports that "by the late 1990s, between one quarter to one third of marrying couples in the United States, Australia, and Britain were attending some form of relationship education" (p. 559). CE has been promoted as a divorce prevention strategy (Halford, 2004; Hunt et al., 1998) and for skills enhancement for couple relationships (Halford, 2004; Larson, 2007).

Typical CE Program Components

Delivery

The delivery of CE programs varies considerably and includes extended in-person groups, weekend groups, or retreats (e.g., Hawes, 1982; Worldwide Marriage Encounter, 2018), questionnaires such as RELATE (Relate Institute, 2019), videos, and online webinars (e.g., Contemporary Relationships, 2019). Larson (2007) reports, "The goals of these programs include providing information about creating a successful relationship, increasing self and partner awareness, providing feedback, initiating cognitive changes, and improving relationship skills" (p. 200). Many programs blend relationship education and enrichment or enhancement (Halford, 2004; Larson, 2007); some include a therapeutic component (Larson, 2007). The appeal of these activities is they are more likely to be evidence-based (Halford, 2004) compared to other CE programs (e.g., CE study groups; cf. Hawes, 1982).

Use of Inventories

Some CEs use inventories as all or part of their intervention with questionnaires completed by the individuals in the couple (Halford, 2004), typically self-report related to communication skills and relationship functions. The couple receives the results and sometimes further intervention (Halford, 2004). Halford reports that these programs "[assess] factors relevant to relationship outcomes" (p. 560) and "provide the opportunity for couples to assess their personal risk and resilience profiles" (p. 560). Research on the lasting effects of this type of intervention is lacking, however, and self-report inventories are not objective.

Skills Training

Skills training refers to "approaches that focus on active training of skills, although these approaches typically also include significant emphasis on building awareness and cognitive change" (Halford, 2004, p. 560). Halford gives numerous examples that have in common "positive communication, conflict management, and positive expression of affection," though they also have "significant variations" (p. 560). The strengths of the skills training approach include its focus on communication, effectiveness, and standardization (Halford, 2004, p. 560). Weaknesses include their "one size fits all" approach (Larson, 2007, p. 203) and the scarcity of sufficiently rigorous research (Larson, 2007).

Focus

Descriptions of CE program participants' concerns vary considerably. Halford (2004) suggests that "it is probably easier for couples with no or mild distress to enhance their relationship than it is for couples who have severe relationship problems to alter entrenched negative patterns and feelings" (p. 559), although others have found greater gains for couples presenting in greater distress (Stanley et al., 2002). Transition points may also offer opportunities for participation in

CE programs, such as in the first two years of marriage, upon the birth of a child, illness in one partner, or in retirement (Baucom et al., 2006; Halford, 2004).

Unfortunately, some authors articulate their focus problematically. Hunt et al.'s *Marriage Enrichment: Preparation, Mentoring, and Outreach* (1998) includes these alienating statements: "There is no other human relationship like a man-woman dyad sanctioned by their society" (p. xii); "In studying marriages, both healthy and unhealthy, we will newly discover the wisdom of the woman-man dyad that cannot be fully matched by other arrangements" (p. xii); and "All of the alternatives to marriage (and/or to family) begin with persons who, for one reason or another, have been unable or unwilling to find satisfaction and success in a woman-man marriage" (p. xiii). Although the authors state that their focus is on marriage enrichment only because of the vastness of the field and that they "applaud those who are addressing these populations" (p. xii), their other comments imply placing higher value on heterosexual couples than on same-sex couples. Their tone is not neutral and may dissuade therapists and partners from utilizing CE programs in the belief that these authors represent the field's stance.

Other issues of language and tone—even if unintentional—are still alienating or perplexing. Although an increasing number of programs indicate that queer couples are welcome, the use of such words as *marital* may be confusing or imply exclusion. It is possible that queer couples will feel invisible when researching such sites as Smart Marriages (2019). Although Smart Marriages asserts that its courses "also work for gay/lesbian couples," they offer no evidence base. On their site, searching for the term *gay* yields several links that include vaguely negative appraisals of queer people. An article on cohabitation includes the out-of-date assertion that same-sex couples cannot marry. Relevant to intersectional considerations is the sweeping and unsupported comment, also on the "singles" page, that the courses work for "all ethnic groups."

Worldwide Marriage Encounter (2018) is one of the oldest CE programs. Participants are expected to be married. That this retreat is for heterosexual couples is clear in the registration form, which asks for "his" and "her" preferred name. Questions about what *marriage* means are answered: "Marriage is a covenant that exists between one man and one woman. Any reference to marriage or couple made by WWME is in this context." WWME states that mixed faith and diverse couples from Protestant, Christian, Jewish, Buddhist, and Muslim faiths, as well as those with no faith affiliation, are welcome to attend. Services are offered in English, Spanish, French, and Korean. The website includes photos of couples of color.

As same-sex marriages become more normative, unclear nomenclature will become more problematic for researchers as well as potential CE clients. Does a workshop advertised for *married couples* include same-sex couples? Couples where one partner is transgender? CEs should identify their criteria explicitly and in inclusive language to facilitate appropriate referrals and provide accurate descriptions of their intended participants.

Research on CE Program Outcomes

It is important to consider general findings on the outcomes of CE programs as well as research on queer partnerships. Most of the research on the effectiveness of CE programs has been conducted with heterosexual couples, and is generally positive. This suggests that a range of CE programs have some utility for male-female couples, and potentially for other partnerships. Yet there are dangers in generalizing favorable outcome research to queer partnerships by assuming relationship similarity. CE program interventions may not work in the same way for queer partners; it is not clear how much identities and intersectionality have been accounted for in research with heterosexual couples. It may very well be that attending to intersectional identities for all CE program participants may improve outcomes, yet one can only speculate since this type of research has not been done.

Still, several reports have found positive outcomes for CE programs. Jakubowski et al. (2004) evaluated 13 programs, finding four "efficacious" (PREP, Relationship Enhancement, Couple Communication Program, and Strategic Hope-Focused Enrichment), three "possibly efficacious" (Couple Care, ACME, and CCET), and six "empirically untested" (Structured Enrichment, Marriage Encounter, PAIRS, Imago, Traits of a Happy Couple, and SYMBIS; pp. 528–530). They describe Gottman's Marriage Survival Kit (Gottman & Gottman, 1999) as insufficiently studied as an intervention but as having "a strong research component in its content" (p. 533).

Larson (2007) provides a helpful summary of program types and clarifies that some of the programs that Jakubowski et al. (2004) described as untested have been evaluated, but not in a sufficiently stringent manner. Larson also describes short CE programs that have promise but have not been well evaluated, such as Marriage Checkups or Tuneups (Gee et al., 2002). One study found that Marriage Checkup had a medium effect on lesbian couples' relationship satisfaction. Thus, a relationship checkup may benefit lesbian as well as heterosexual couples (Minten & Dykeman, 2019).

Sullivan and Goldschmidt (2000) report on client satisfaction with short CE programs in a managed-care setting. Although Hawley and Olson's (1995) findings were equivocal, participants in the programs they studied were highly satisfied with their program. Baucom et al. (2006) report that relationship education programs such as PREP can help prevent marital distress among newlyweds. Studies of some CE programs, including the Minnesota Couple Communication Program, found mixed results (Wampler & Sprenkle, 1980). Reardon-Anderson et al. (2005) assert that "generally there is promising evidence that couples can learn specific skills to improve their relationships" (p. 3). Doss et al. (2016) examined OurRelationship, an eight-hour online program adapted from an empirically based couple therapy including online activities and phone calls with staff. A nationally representative sample of heterosexual couples found significant improvements in relationship satisfaction and confidence.

In addition to these generally positive findings, problems have been identified. Halford (2004) notes the need for longer-term outcome evaluations. A prominent marital researcher agrees that evaluation occurring soon after the intervention probably results in overinflated positive outcomes or a "workshop effect" (Robert L. Weiss, personal communication, May 23, 2010). Doherty and Walker (1982) found that some Marriage Encounter participants experienced distress. Since none of the studies summarized above appear to have included queer participants, it is impossible to assert that research to date supports the efficacy of CE programs for these groups. However, there is reasonably good evidence from the Gottman Institute (2019) and Kurdek (2004), as well as others, supporting the use of CE programs with queer couples based on characteristics of couple communication that hold across relational orientations.

Social Issues Faced by Queer Partnerships

The Gottman Institute articulates the relationship between general couples' concerns and specific queer couples' concerns:

> Gay and lesbian couples, like straight couples, deal with every day ups-and-downs of close relationships…. We know that these ups-and-downs may occur in a social context of isolation from family, workplace prejudice, and other social barriers that are unique to gay and lesbian couples.
>
> *(Lisitsa, 2012)*

Even a healthy queer relationship takes place in a cultural context that poses stressors. Meyer (1995) found that gay men experience minority stress, and it is well documented that experiences of discrimination, threats, and other social stressors are present in many queer people's

lives (Kurdek, 2004). Queer people face unique social stressors related to their partner relationships, both prior to (Cao et al., 2017) and after legalization of same-sex marriage (Garcia & Umberson, 2019; LeBlanc et al., 2018).

Discriminatory adoption policies can be another significant stressor. Dobrin (2017) reports on a lesbian Michigan couple who were denied the opportunity to adopt on the basis of their sexual orientation. Almost half of U.S. states continue to allow adoption agencies to deny placements with queer couples based on religious beliefs (Movement Advancement Project, 2021). At present, U.S. government policy is shifting *away* from protections and rights for queer people, most prominently transgender populations (American Psychological Association, 2018). All forms of social stress increase the need for an adequate understanding of risk and resilience, good assessment, and interventions that are a useful match for the partnership.

Stress and Vulnerability

In addition to social stressors, other specific vulnerabilities and risks may be relevant for members of queer partnerships. These should be assessed within each partnership when determining the relevance and utility of a CE referral. Since queer couples may be similar to heterosexual couples along many dimensions, it is not surprising that they suffer from similar stressors. Patterson (2000) describes "different religious, racial, ethnic, or socioeconomic backgrounds" and values as relational stressors, as well as "problems at either partner's job, financial pressures on the couple, [and] friction with members of extended family networks" (p. 1054). She cites Kurdek's finding that "the top five areas of conflict for lesbian and gay couples were finances, driving style, affection/sex, being overly critical, and division of household tasks" (p. 1054), a familiar list for heterosexual couples.

The Gottman Institute summarizes its research findings on behaviors that destroy relationships, the well-known "Positive-to-Negative Ratio of 0.8 or Less" and "The Four Horsemen of the Apocalypse": Criticism, contempt, defensiveness, and stonewalling. They identify a gender difference relevant to same-sex couples:

> [M]en tend to react with more signs of physiological stress…during disagreements, and therefore, men are more likely to withdraw (stonewall). (It is interesting to note that we have also followed same-sex couples, and stonewalling occurs between them as well.)
>
> *(Gottman Institute, 2019)*

Other stressors may be relevant to queer and male-female relationships. These include risk of HIV/AIDS (Patterson, 2000, p. 1055) and Kurdek's finding (1998) that gay men and lesbians reported more frequent ends to their relationships (presumably because they also reported fewer barriers to leaving). Minten and Dykeman (2019) note that lesbian and gay relationships are more likely to terminate, and that this risk is associated with stigma.

Some couples may decide to attend a retreat because one partner has recently come out as transgender or decided to begin to transition. When these identity development milestones occur within a long-standing romantic partnership, they may be associated with distress, rejection by family members and other social supports, the financial costs of transitioning, and navigating sexuality and identity within the partnership (Erhardt, 2007; Samons, 2008).

Strength and Resilience

Research has also identified many areas of strength for queer couples. These include more autonomy for gay and lesbian partners and more intimacy and equality in lesbian couples (Kurdek, 1998). Patterson (2000) found that the research on same-sex couples showed overall "positive

adjustment, even in the face of stressful conditions" (p. 1052). In studies she reviewed, most lesbians and gay men reported happiness and positive relationships. A Gottman study of gay and lesbian couples characterized them as more "upbeat," affectionate, humorous, and positive during and after conflict. Indeed, "Straight couples may have a lot to learn from gay and lesbian relationships." Gay and lesbian couples "use fewer controlling, hostile emotional tactics… [thereby suggesting] that fairness and power-sharing between the partners [are] more important and more common in gay and lesbian relationships than in straight ones"; they also "accept some degree of [interpersonal] negativity without taking it personally"; and reversing the pattern of heterosexual couples, they are physically calmer, though "lesbians are more emotionally expressive" and "[g]ay men need to be especially careful to avoid negativity in conflict" (Lisitsa, 2012).

Patterson (1994) notes that "lesbian and gay individuals and couples are believed to be more likely than heterosexuals to count close friends and ex-lovers as family members" and, in fact, "ex-lovers are particularly likely to be represented in such networks, especially among lesbians" (p. 63; see also Burgoyne, 2001). It is important to consider the strengths of such extended family networks on queer relational functioning. Ideally, these areas of queer resilience will shape strength-based interventions not only for queer partnerships but for heterosexuals as well.

Indicators of relationship health and well-being for queer relationships include relational satisfaction, sexual satisfaction, conflict, closeness, intimacy, commitment, thoughts of termination, and termination (Frost et al., 2015)—all concepts that fall under the umbrella of relational well-being (Prilleltensky, 2005; Ryff, 1995). Unfortunately, the literature on partnerships with at least one bisexual or transgender partner is minimal, and points to the need for work in this area.

Recommendations for CE Program Assessment and Referral

Because many CE programs do not pre-screen, therapists should evaluate the appropriateness of the referral. Although instruments such as Burgoyne's (2001) Relationship Assessment Measure for Same-Sex Couples (RAM-SSC) might help evaluate couples for CE referral, it may be easier to assess each partner's interpersonal risk and resilience through an informal interview. Burgoyne (2001) suggests exploring

> …the availability of role models and social support for the couple, the history of family interactions and degree of closeness versus emotional cut-off from extended family, self-image in the context of gay identity, habitual responses to stress, style of seeking information and help, role flexibility, and the impact of concordant or discordant HIV status (where relevant) on sexuality and the relationship in general. The effects of cumulative losses within the couple's network because of HIV/AIDS should also be assessed.
>
> *(pp. 285–286)*

An interview based on Bronfenbrenner's self-in-context model may also be useful (Chronister et al., 2004). This interview assesses clients' risk and resilience factors in their social ecologies, including physical characteristics, close relationships, intersecting or diverging relationship systems, policies and media exposure, cultural beliefs, and changes over time. This structure reminds the therapist to evaluate the client's strengths and vulnerabilities at interpersonal and sociocultural levels, and not to neglect the client's intersectionality and group identities in addition to their queer identities. Other tools for exploring intersectionality (e.g., Hays, 2016; Kliman, 2010) similarly foreground multiple and intersectional identities. Client-centered interviewing, with attention to intersectional considerations, helps the therapist adhere to the standards of the American Psychological Association's *Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients* (2011), *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People* (2015), and *Guidelines for Providers of Psychological Services to Ethnic,*

Linguistic, and Culturally Diverse Populations (1990). Intake forms, interviews, or instruments administered in an evaluation for services or referral should not assume heterosexuality, gender, or a dyadic relationship. If these questions cannot be edited due to norming or other constraints, this issue should be discussed with clients.

We offer several recommendations to therapists referring their clients to CE activities, bearing in mind that most CE programs are not intersectionally sufficient:

1. Evaluate the clients' readiness for a CE program.
2. Become familiar with CE programs that may be a good match for clients' needs (e.g., a particular focus, low cost, online, religious affiliation, attention to intersectional identities).
3. Review the CE program thoroughly. Check online for content and tone. This could be a homework assignment for clients.
4. Refer to CE programs with expertise working with queer clients. If this is not feasible, refer to CE programs that welcome queer participants.
5. For relationships that have at least one bisexual or transgender partner, discuss the scarcity of CE programs specifically geared to their needs. Discuss queer-affirmative programs to see if one is a good fit.
6. If clients are interested in a CE program that has not demonstrated efficacy, discuss how the clients might evaluate the goodness of fit and potential outcomes.
7. If no formal CE program is available, feasible, or attractive, consider meeting some of the same needs through bibliotherapy using self-help books for queer relationships.

Recommendations for CE Program Providers

> Chris, a coordinator for a queer-affirmative CE program, decides to partner with a local trans-focused non-profit to increase trans-affirmative practices. Chris hopes to update online materials and weekend programming, and hire trans staff. Chris hopes the program will serve trans partnerships in the region and country.

We suggest several key recommendations to creators and facilitators who hope to offer queer-affirmative, intersectionally responsive CE programs:

1. Providers must examine their biases, beliefs, and attitudes toward queer individuals and families (Burkholder & Burbank, 2012).
2. CE programs must address intersectional and identity-related strengths, stressors, prejudice, discrimination, oppression, and related variables. Raising participants' critical consciousness of these issues should sensitize and benefit all CE participants.
3. State clearly whether queer clients are welcome and whether your program is relevant to their needs (Halford, 2004). State whether consensual non-monogamous couples (CNM) are welcome.
4. If queer clients are welcome, be sure that registration and other materials reflect this. Use language that includes CNM clients to create a safety for disclosure and to validate their experience and identity (Schechinger, 2017).
5. Programs can welcome transsexual/transgender participants by following the American Psychological Association's guidelines (2015). Use trans-affirmative programming, offer all-gender restrooms, normalize pronouns, and set group norms about inappropriate or invasive questions related to participants' identities, including gender. Some transgender participants will prefer to keep their gender identity private, and we encourage facilitators to respect this.

6. If an inventory or other materials includes heterosexist bias or excludes queer people, consult about whether the language can be changed without affecting norming if the data will be used for research.
7. Have queer consultants review materials for possible misstatements or problems. For example, the terms *gay women* and *homosexual* are not in favor, *transgender* and *transsexual* have related but distinct meanings, and *marital* is not a neutral term.
8. Materials should show same-sex couples as well as male-female pairs. Videos or webinars that present case studies should include queer couples.
9. Use materials that reflect the relational concerns of bisexual and transgender partners.
10. CE programs welcoming consensual non-monogamous (CNM) clients should address issues specific to CNM clients, including jealousy management and the differences between coming out as non-monogamous and coming out as queer.
11. In-person CE programs must consider the impact of other participants' potential homophobia on queer participants. Materials should reflect the mixed nature of the group and facilitators should be ready to address the possibility of bias or inappropriate statements by group members.
12. Conduct focus groups with queer community members to determine whether your program's content, inventories, and skills training will be a good fit.
13. Conduct outcome research with queer participants, especially if you are able to conduct long-term studies.
14. Periodically review website links. Links that are confusing, dead, or use automated news feeds that may capture objectionable articles may discourage clients who are not sure that this CE program is a good fit.

Contemporary Programs and Other Options

Fortunately, several CE programs are appropriate for queer clients, although they should still be evaluated for intersectional proficiency. First, although not a queer-specific program, RELATE (Relate Institute, 2019) is an inventory that returns results in generally gender-neutral language. As do all programs administered at a distance, it raises fewer concerns about couples' privacy and potential stigma. Gay Couples Institute (2007–2019) offers weekend workshops for gay men and lesbians based on Gottman's work. Bisexual and transgender relationships do not appear to be a focus. Contemporary Relationships (2019) offers online CE programs and in-person workshops. The site identifies queer couples as its focus, although there is not yet content specific to bisexual and transgender people. As the program expands, it will add webinars specific to these groups, as well as other queer-related content. Since some organizations offer a mix of CE programs and other couple-related education and activities, it is worthwhile to examine additional interventions and research to identify activities that may be particularly relevant to queer partnerships. For example, Picucci (1992) described a weekend workshop for lesbians and gay men focused on psychological wounds and healing through experiential activities. Page (2009) discusses the utility of a group intervention using gift theory to promote psychological health and community building for gay, bisexual, and transgender people.

Helpful Therapist and Facilitator Characteristics

Professionals should be up to date on the research and theoretical literature on relational work with queer clients and their additional identities. This includes reviewing assumptions about relationships, queer people, and intersectional identities, as well as revisiting previous learning and assumptions.

It is also helpful to be familiar with general relational wellness literature and to consider an assets- or strengths-based approach to the partners' presenting issues. Overemphasizing problems may make it more difficult to identify strengths. In conjunction with this focus, it is important not to misinterpret the literature on couples' or queer people's problems. Professionals should seek resources that illuminate aspects of bisexual and transgender people's couple experiences, such as Reinhardt (2002), Israel (2004), and Kins et al. (2008). Being queer therapists or facilitators is no guarantee that professionals will not experience countertransference or other responses to queer partnerships. In addition to queer issues, sexual discussion, violence, monogamy, multiple partners, or the army of ex-lovers living with the partners may evoke professionals' emotional responses and irrational beliefs. Consistent consultation is always a priority.

We recommend that therapists consider attending a CE program as clients. In addition to potential benefits in their own relationships, the experience will yield insights about the program, as well as the goodness of fit for particular clients. A colleague reflects on her experience:

> My partner and I recently participated as clients in a CE retreat. As a queer cisgender woman in a male-female couple, I noticed that the overarching tone of the program was gender-binary and heterosexist. At one point, men and women were divided into two groups. Men were encouraged to nourish the relationship, make space for intimacy, and ask about their partner's needs during sex, while women were asked to beautify themselves and were encouraged to express gratitude and appreciation for their partners. Although the facilitators shared their support for discarding the patriarchal rules of marriage, they still emphasized that men and women are opposites.
>
> Although the program was geared toward monogamous heterosexual partners, the skills, strategies, and opportunities for connection we experienced were largely universal. I asked the facilitators how they might be more inclusive. They shared an anecdote about a time when a lesbian partner asked to be included in the male circle but was denied on the basis of her gender and because her presence might cause discomfort for the men. This couple was not provided with all of the CE's services in the same way that the male-female couples were.
>
> I wondered how simple and impactful it would be to tailor the program to be more inclusive of queer, bisexual, transgender, and gender nonconforming partnerships.

Recommendations for Future Research on CE

As noted, a weakness of CE programs in general is the idea that one size fits all. This weakness is even more true of CE programs for queer partners, who may not be similar to the presumptively heterosexual couples on whom the instruments and interventions were normed, and whose outcomes have been studied, even before considering the possible effects of clients' additional identities. Further, there are within-group differences between queer individuals. Some relationships may be polyamorous or triad or consensually non-monogamous. These variations in identity and relationship composition may or may not be relevant to CE program effectiveness, but we will not know until they are studied.

Research on both CE programs and queer people typically has been conducted with participants who do not adequately represent the range of human diversity. We know a reasonable amount about white, middle-class couples, but much less about other groups. Similarly, we do not know that the male-female couples presented in the literature to date would identify themselves as heterosexual, though researchers have presumed them to be. This assumption alone suggests the strong need for more rigorous screening in which CE research asks participants about their sexual orientation, gender identity, and intersectionality. Without these data, it is difficult to know whether the norms generated by the research are accurate and representative.

Conclusion

CE programs began as a religiously inspired premarital intervention for heterosexual couples, without reference to queer couples or other relational constellations. Over time, CE programs have broadened in methods and scope. The increasing visibility and cultural acceptance of queer people has led to a commensurate increase in research on queer relationships and, in some cases, greater flexibility or welcome to queer couples in CE programs. Some programs now include activities intended to meet the specific needs of queer couples. However, CE programs still vary considerably in the extent to which they explicitly address the needs of queer relationships. Lack of specificity and clarity presents a marketing problem for programs trying to reach their intended participants and a customer problem for all partners trying to find interventions to support and enrich their relationships. The lack of clear information and population-specific considerations is particularly acute for bisexual, transsexual/transgender, and CNM clients, and specific address to queer plus intersectional identities is virtually non-existent. These are areas desperately in need of empirical exploration.

References

American Psychological Association. (1990). *Guidelines for providers of psychological services to ethnic, linguistic, and culturally diverse populations*. https://www.apa.org/pi/oema/resources/policy/provider-guidelines

American Psychological Association. (2011). *Guidelines for psychological practice with lesbian, gay, and bisexual clients.* http://www.apa.org/pi/lgbt/resources/guidelines.aspx

American Psychological Association. (2015). Guidelines for psychological practice with transgender and gender nonconforming people. *American Psychologist, 70*(9), 832–864. https://doi.org/10.1037/a0039906

American Psychological Association. (2018). *Public policies, prejudice, and sexual and gender minority health.* https://www.apa.org/advocacy/civil-rights/sexual-diversity/gender-minority-health.pdf

Baucom, D. H., Hahlweg, K., Atkins, D. C., Engl, J., & Thurmaier, F. (2006). Long-term prediction of marital quality following a relationship education program: Being positive in a constructive way. *Journal of Family Psychology, 20*(3), 448–455. https://doi.org/10.1037/0893-3200.20.3.448

Burgoyne, R. W. (2001). The Relationship Assessment Measure for Same-Sex Couples (RAM-SSC): A standardized instrument for evaluating gay couple functioning. *Journal of Sex & Marital Therapy, 27*(3), 279–287. https://doi.org/10.1080/009262301750257137

Burkholder, G. J., & Burbank, P. (2012). Caring for lesbian, gay, bisexual, and transsexual parents and their children. *International Journal of Childbirth Education, 27*(4), 12–18.

Cao, H., Zhou, N., Fine, M., Liang, Y., Li, J., & Mills, K. W. R. (2017). Sexual minority stress and same-sex relationship well-being: A meta-analysis of research prior to the US Nationwide legalization of same-sex marriage. *Journal of Marriage and Family*, *79*(5), 1258–1277. https://doi.org/10.1111/jomf.12415

Chronister, K. M., McWhirter, B. T., & Kerewsky, S. D. (2004). Prevention from an ecological framework. In R. K. Coyne & E. P. Cook (Eds.), *Ecological counseling: An innovative approach to conceptualizing person-environment interaction* (pp. 315–338). ACA Press.

Conley, T. D., Moors, A. C., Matsick, J. L., & Ziegler, A. (2013). The fewer the merrier?: Assessing stigma surrounding consensually non-monogamous romantic relationships. *Analyses of Social Issues and Public Policy, 13*(1), 1–30. https://doi.org/10.1111/j.1530-2415.2012.01286.x

Contemporary Relationships. (2019). https://www.contemporaryrelationships.com

Dobrin, I. (2017, September 23). *ACLU sues Michigan after same-sex couples seeking to adopt are rejected.* https://www.npr.org/2017/09/23/552873416/aclu-sues-michigan-after-same-sex-couples-seeking-to-adopt-are-rejected

Doherty, W. J., & Walker, B. J. (1982). Marriage Encounter casualties: A preliminary investigation. *American Journal of Family Therapy, 10*(2), 15–25. https://doi.org/10.1080/01926188208250444

Doss, B. D., Cicila, L. N., Georgia, E. J., Roddy, M. K., Nowlan, K. M., Benson, L. A., & Christensen, A. (2016). A randomized controlled trial of the web-based OurRelationship program: Effects on relationship and individual functioning. *Journal of Consulting and Clinical Psychology, 84*(4), 285–296. https://doi.org/10.1037/ccp0000063

Erhardt, V. (2007). *Head over heels: Wives who stay with cross-dressers and transsexuals.* Haworth.

Fein, L. A., Salgado, C. J., Sputova, K., Estes, C. M., & Medina, C. A. (2018). Sexual preferences and partnerships of transgender persons mid- or post-transition. *Journal of Homosexuality, 65*(5), 659–671. https://doi.org/10.1080/00918369.2017.1333808

Frost, D. M., Meyer, I. H., & Hammack, P. L. (2015). Health and well-being in emerging adults' same sex relationships. Critical questions and directions for research in developmental science. *Emerging Adulthood, 3*(1), 3–13. https://doi.org/10.1177/2167696814535915

Garcia, M. A., & Umberson, D. (2019). Marital strain and psychological distress in same-sex and different-sex couples. *Journal of Marriage and Family, 81*(5), 1253–1268. https://doi.org/10.1111/jomf.12582

Gay Couples Institute. (2007–2019). https://www.gaycouplesinstitute.org/

Gee, C. B., Scott, R. L., Castellani, A. M., & Cordova, J. V. (2002). Predicting 2-year marital satisfaction from partners' discussion of their marriage checkup. *Journal of Marital and Family Therapy, 28*(4), 399–407. https://doi.org/10.1111/j.1752-0606.2002.tb00365.x

Gottman Institute. (2019). https://www.gottman.com/

Gottman, J. M., & Gottman, J. S. (1999). The marriage survival kit: A research-based marital therapy. In R. Berger & M. T. Hannah (Eds.), *Preventive approaches in couples therapy* (pp. 304–330). Brunner/Mazel.

Halford, W. K. (2004). The future of couple relationship education: Suggestions on how it can make a difference. *Family Relations, 53*(5), 559–566. https://doi.org/10.1111/j.0197-6664.2004.00065.x

Hawes, E. C. (1982). Couples growing together: Couple enrichment programs. *Individual Psychology, 38,* 322–331.

Hawley, D. R., & Olson, D. H. (1995). Enriching newlyweds: An evaluation of three enrichment programs. *American Journal of Family Therapy, 23*(2), 129–147. https://doi.org/10.1080/01926189508251344

Hays, P. A. (2016). *Addressing cultural complexities in practice: Assessment, diagnosis, and therapy* (3rd ed.). American Psychological Association. https://doi.org/10.1037/14801-000

Hunt, R. A., Hof, L., & DeMaria, R. (1998). *Marriage enrichment: Preparation, mentoring, and outreach*. Brunner/Mazel.

Israel, G. E. (2004). Supporting transgender and sex reassignment issues: Couple and family dynamics. In J. E. Bigner & J. L. Wetchler (Eds.), *Relationship therapy with same-sex couples* (pp. 53–63). Haworth. https://doi.org/10.1300/J398v03n02_06

Jakubowski, S. F., Milne, E. P., Brunner, H., & Miller, R. B. (2004). A review of empirically supported marital enrichment programs. *Family Relations, 53*(5), 528–536. https://doi.org/10.1111/j.0197-6664.2004.00062.x

Kins, E., Hoebeke, P., Heylens, G., Rubens, R., & De Cuypere, G. (2008). The female-to-male transsexual and his female partner versus the traditional couple: A comparison. *Journal of Sex & Marital Therapy, 34*(5), 429–438. https://doi.org/10.1080/00926230802156236

Kliman, J. (2010, Winter). Intersections of social privilege and marginalization: A visual teaching tool. *AFTA Monograph Series, Special Issues: Expanding on Social Justice Practices* (pp. 39–48). American Family Therapy Academy. https://www.researchgate.net/publication/270579596_Intersections_of_Privilege_andMarginalization_A_Visual_Teaching_Tool

Kurdek, L. A. (1998). Relationship outcomes and their predictors: Longitudinal evidence from heterosexual married, gay cohabiting, and lesbian cohabiting couples. *Journal of Marriage and Family, 60*(3), 553–568. https://doi.org/10.2307/353528

Kurdek, L. A. (2004). Are gay and lesbian cohabiting couples *really* different from heterosexual married couples? *Journal of Marriage and Family Therapy, 66*(4), 880–900. https://doi.org/10.1111/j.0022-2445.2004.00060.x

Larson, J. H. (2007). Couple enrichment approaches. *Journal of Couple and Relationship Therapy, 6*(1–2), 197–206. https://doi.org/10.1300/J398v06n01_16

LeBlanc, A. J., Frost, D. M., & Bowen, K. (2018). Legal marriage, unequal recognition, and mental health among same-sex couples. *Journal of Marriage and Family*, *80*(2), 397–408. https://doi.org/10.1111/jomf.12460

Lisitsa, E. (December 14, 2012). *The 12 year study.* https://www.gottman.com/blog/the-12-year-study/

Meyer, I. H. (1995). Minority stress and mental health in gay men. *Journal of Health and Social Behavior, 36*(1), 38–56. https://doi.org/10.2307/2137286

Minten, M. J., & Dykeman, C. (2019). The impact of relationship wellness checkups with lesbian couples. *The Family Journal, 27*(1), 50–57. https://doi.org/10.1177/1066480718809429

Movement Advancement Project. (2021). *Foster and adoption laws.* http://www.lgbtmap.org/equality-maps/foster_and_adoption_laws

Page, K. (2009). Gift theory: A new theoretical construct and its application to gay, bisexual, and transgender men in large-group retreats. *Group, 33*, 235–244.

Patterson, C. J. (1994). Lesbian and gay families. *Current Directions in Psychological Science,* 3(2), 62–64. https://doi.org/10.1111/1467-8721.ep10769976

Patterson, C. J. (2000). Family relationships of lesbians and gay men. *Journal of Marriage and the Family, 62*(4), 1052–1069. https://doi.org/10.1111/j.1741-3737.2000.01052.x

Picucci, M. (1992). Planning an experiential weekend workshop for lesbians and gay males in recovery. *Journal of Chemical Dependency Treatment, 5*(1), 119–139. https://doi.org/10.1300/J034v05n01_10

Prilleltensky, I. (2005). Promoting well-being: Time for a paradigm shift in health and human services. *Scandinavian Journal of Public Health, 33*(66 suppl.), 53–60. https://doi.org/10.1080/14034950510033381

Reardon-Anderson, J., Stagner, M., Macomber, J. E., & Murray, J. (2005). *Systematic review of the impact of marriage and relationship programs*. http://www.urban.org/url.cfm?ID=411142

Reinhardt, R. U. (2002). Bisexual women in heterosexual relationships. *Journal of Bisexuality, 2*(2–3), 163–171. https://doi.org/10.1300/J159v02n02_11

Relate Institute. (2019). https://relateinstitute.com/

Rest Stop. (1999). *The history of Marriage Encounter*. http://www.reststop.com/info/marriage/history.html

Ryff, C. D. (1995). Psychological well-being in adult life. *Current Directions in Psychological Science, 4*(4), 99–104. https://doi.org/10.1111/1467-8721.ep10772395

Samons, S. (2008). *When the opposite sex isn't: Sexual orientation in male-to-female transgender people.* Routledge.

Schechinger, H. A. (2017, June). Toward inclusive science and practice: Here's what you need to know about consensually non-monogamous relationships. *American Psychological Association Division 44 Newsletter.* http://www.apadivisions.org/division-44/publications/newsletters/division/2017/06/non-monogamy.aspx

Schechinger, H. A., Sakaluk J., & Moors, A. (2018). Harmful and helpful therapy practices with consensually non-monogamous clients: Toward an inclusive framework. *Journal of Consulting & Clinical Psychology, 86*(11), 879–891. https://doi.org/10.1037/ccp0000349

Smart Marriages. (2019). http://www.smartmarriages.com/index.html

Stanley, S. M., Markman, H. J., & Jenkins, N. H. (2002, March 4). *Marriage education and government policy: Helping couples who choose marriage achieve success.* https://www.smartmarriages.com/choose.marriage.html

Sullivan, K. T., & Goldschmidt, D. (2000). Implementation of empirically validated interventions in managed-care settings: The prevention and relationship enhancement program. *Professional Psychology: Research and Practice, 31*(2), 216–220. https://doi.org/10.1037/0735-7028.31.2.216

Wampler, K. S., & Sprenkle, D. H. (1980). The Minnesota Couple Communication Program: A follow-up study. *Journal of Marriage and Family, 42*(3), 577–584. https://doi.org/10.2307/351901

Wood, J., Desmarais, S., Burleigh, T., & Milhausen, R. (2018). Reasons for sex and relational outcomes in consensually nonmonogamous and monogamous relationships: A self-determination theory approach. *Journal of Social and Personal Relationships, 35*(4), 632–654. https://doi.org/10.1177/0265407517743082

Worldwide Marriage Encounter. (2018). www.wwme.org

Worthington, E. L., Jr., Ripley, J. S., Hook, J. N., & Miller, A. J. (2007). The hope-focused approach to couple therapy and enrichment. *Journal of Psychology and Christianity, 27*(2), 132–139.

Taylor & Francis
Taylor & Francis Group
http://taylorandfrancis.com

Section V
Training Issues

Taylor & Francis
Taylor & Francis Group
http://taylorandfrancis.com

23

"Why Can't We Just Learn about Normal Couples?"

LGBQ Affirmative Training Strategies for CFT Faculty and Programs

CHRISTI R. MCGEORGE, ASHLEY A. WALSDORF, and KATELYN O. COBURN

The literature clearly highlights the need for couple and family therapists (CFTs) to be prepared to work with lesbian, gay, bisexual, and queer clients (LGBQ[1]; Bernstein, 2000; Edwards et al., 2014; Hartwell et al., 2012; Henke et al., 2009; Rock et al., 2010). Specifically, research suggests that LGBQ individuals seek therapy services at a rate of 25%–77%, which is two to four times the rate of heterosexual individuals (Cochran et al., 2003). Given the likelihood that CFTs will have LGBQ clients in their caseloads, they must be prepared to provide skillful and just services to this population.

Over the past two decades, researchers and educators have been critical of the lack of training CFTs receive to work with LGBQ clients (Godfrey et al., 2006; Long, 1996; Long & Serovich, 2003; McGeorge & Carlson, 2016; Rock et al., 2010). Several studies have corroborated this critique, finding that graduate students in clinical training programs reported feeling inadequately prepared to provide competent therapy to LGBQ clients (Anhalt et al., 2003; Carlson et al., 2013; Rock et al., 2010). For example, Rock et al. (2010) found that 60.5% of their sample of 190 students in accredited CFT programs reported that they received no training on LGBQ affirmative therapy practices. This lack of LGBQ affirmative training is problematic, particularly since it is associated with students' self-reported clinical competence with LGBQ clients (Rock et al., 2010). With graduate school being the primary training agent for therapists, the absence of LGBQ affirmative training is likely to lead to therapist inadequacy in this area (Dworkin & Gutierrez, 1989).

In addition to the overall lack of training provided in clinical programs, there remains a dearth of published work that addresses working with LGBQ clients (Hartwell et al., 2012). In particular, a content analysis revealed that only 173 (2%) of the 8,781 articles published from 1996 to 2009 in the 17 primary family therapy-related journals addressed topics relevant to LGBQ people (Hartwell et al., 2012). To determine if this lack of scholarly research paralleled continuing education opportunities, we reviewed the conference presentations on LGBQ topics for the 2009 American Association for Marriage and Family Therapy (AAMFT) annual conference. In 2009, only four (3.5%) of the 113 presentations and five (4.1%) of the 121 posters focused on topics relating to sexual orientation. We then contrasted these findings with the topical composition of the 2018 AAMFT conference. In 2018, seven (6.5%) of the 107 presentations and 12 (9.4%) of the 128 research discussions (previously poster presentations) focused on sexual orientation. The limited increase in affirmative training opportunities at the AAMFT conferences,

[1] Although lesbian, gay, bisexual, and transgender individuals are often grouped together, this chapter focuses on sexual orientation rather than gender identity and expression, which are explored in other chapters in this volume. Additionally, queer is used to acknowledge the broad range of non-binary sexual orientations (e.g., pansexual, demisexual) as well as to recognize queer as an identity in its own right.

DOI: 10.4324/9780429274626-29

coupled with the lack of preparation students report, suggests that there continues to be a need for inclusive training to ensure that all clients receive ethical and just clinical services.

A primary challenge to the CFT field in becoming increasingly affirmative is the immense influence of heteronormativity, a pervasive societal belief in the inherent normalcy and value of opposite-sex relationships. Heteronormative beliefs often inform all levels of the systems they surround, ranging from national policies that limit LGBQ people to the content that is included in CFT training programs. Heteronormativity thus drives students and faculty members' lack of preparedness to work with LGBQ clients, in addition to CFT programs' readiness to create such a learning environment.

This chapter focuses on training in LGBQ affirmative therapy, which is defined in the literature as "an approach to therapy that embraces a positive view of LGB[Q] identities and relationships and addresses the negative influences that homophobia and heterosexism have on the lives of LGB[Q] clients" (Rock et al., 2010, p. 175). Importantly, affirmative training involves not only teaching about topics related to LGBQ identities but also helping CFT students develop positive beliefs and attitudes about LGBQ communities. The primary components of LGBQ affirmative therapy are (a) therapists' self-awareness about their own biases and beliefs; (b) knowledge about LGBQ related topics (e.g., the historic struggle for civil rights, state and federal laws that both discriminate against and support LGBQ communities); (c) clinical abilities applying these topics, including acknowledging experiences of discrimination and assisting clients in navigating a heterosexist society; and (d) skills related to advocacy both within and outside of the therapy room. The aim of this chapter is to help aid faculty in their preparation of students through fostering the self-awareness and knowledge necessary to provide competent therapy services to LGBQ clients. Following a review of the literature, the chapter details strategies for faculty ranging from more individual-level to more systems-level suggestions. These include self-of-the-faculty work, training and educational strategies, and, finally, transformational ideas CFT programs might implement to create more inclusive and affirmative program environments. Each strategy section concludes with a brief case illustration and questions for reflection.

Literature Review

The following section reviews the available literature on LGBQ affirmative therapy, including (a) the practice of LGBQ affirmative therapy, (b) preparing students to provide affirmative therapy, and (c) challenges of training students in LGBQ affirmative therapy.

The Practice of LGBQ Affirmative Therapy

The literature on LGBQ affirmative therapy practice highlights two primary areas of therapist development: a process of critical self-reflection and developing specific skills to work with LGBQ clients (Coburn & McGeorge, 2019; Long & Lindsey, 2004; Matthews, 2007; McCann, 2001; McGeorge & Carlson, 2011). The goal of the self-reflection process is to foster and/or strengthen a belief system that is honoring of marginalized identities, which leads to identifying pathology in systemic and individual prejudices rather than in clients' identities (Davies, 2000). In addition to believing in the legitimacy of all sexual orientations, the literature suggests that therapists must conduct a thorough exploration of their own attitudes and values related to LGBQ identities and relationships. This may include an examination of what therapists have learned from their own families of origin in order to determine if those values are inclusive of LGBQ individuals, couples, and families (McGeorge & Carlson, 2011). The work of becoming an LGBQ affirmative therapist starts with identifying and labeling one's own prejudicial and heterosexist beliefs and, thus, begins long before clients report their sexual orientation (Bernstein, 2000; Matthews, 2007; McGeorge & Carlson, 2011). If this work is not done, therapists are likely to engage in behaviors that represent micro- or macro-aggressions towards their LGBQ clients.

For example, if self-explorations about the dominant societal messages assuming the normalcy of a heterosexual identity have not occurred, a therapist may refer to a new client's partner using opposite-gender pronouns, which is a mistake that could be harmful to both the client and the development of a positive therapeutic relationship.

In addition to engaging in self-reflection, LGBQ affirmative therapy training involves gaining knowledge of relevant issues in the lives of LGBQ clients and staying up to date with research on LGBQ topics (McCann, 2001). In particular, the literature suggests that therapists need to be knowledgeable about the effects of internalized heterosexism, lifelong coming out processes, minority-related stress, current and historic struggles for basic civil rights, resources available for LGBQ communities, and heterosexual bias and privilege (Bernstein, 2000; Greene, 2007; McGeorge & Carlson, 2011, 2016; Meyer, 1995). Knowledge and awareness of these areas is an essential precursor to providing informed, ethical therapy that fully affirms LGBQ individuals, couples, and families.

Preparing Students to Provide LGBQ Affirmative Therapy

Preparing students to provide LGBQ affirmative therapy involves offering training that departs from a heterosexual/heterosexist worldview and develops students' awareness of their own values and biases regarding sexual orientation. It also includes helping students gain the critical awareness necessary to explore the concepts of internalized and institutional heterosexism in addition to their own potential areas of privilege (Godfrey et al., 2006; McGeorge et al., 2018). Although students need to be taught specialized skills to address the sexual minority prejudice and heterosexism that LGBQ clients experience in society and in their families, they also need to understand that LGBQ clients seek therapy for many of the same reasons as heterosexual clients.

Additionally, students need to be trained to avoid viewing LGBQ individuals as a homogenous group but instead see the diversity that exists within these communities (Greene, 2007). Indeed, diversity exists within sexual orientation itself in that some people experience emotional and sexual desire beyond binary understandings of gender and sexuality (Oswalt et al., 2016). This may include attraction to all genders or perhaps partnerships based on emotional connection over or before physical attraction (Diamond, 2016). With this in mind, faculty should teach students about variations in the types of sexual orientation identities and highlight that different types of love, desire, and/or relationships do not always align with heteronormative expectations for partnerships. Moreover, it is important to teach students about intersectionality and the multiple forms of oppression that LGBQ clients may experience based on overlapping identities beyond sexual orientation (e.g., gender, race, social economic status, and other social locations). To illustrate, an individual who is marginalized on the basis of both their racial identity and sexual orientation is likely to experience compounded oppression. For example, Johny is an 18-year-old, Latinx immigrant who came to the United States undocumented with his parents when he was a child. Johny is seeking therapy for help sharing his queer identity with his parents, who he fears will disown him based on their religious beliefs. However, due to his undocumented status, Johny does not have access to health insurance, and is concerned about being reported to federal authorities, which could lead to his deportation (Crenshaw, 1989). Intersectional LGBQ affirmative training involves situating clients' experiences of power and oppression within the structural and societal inequalities created by unjust systems (Grzanka & Miles, 2016). In the case of Johny, this includes national policies and societal rhetoric that not only negatively impact his LGBQ identity, but also his movement, safety, and access to resources as an immigrant.

Another key component of preparing students to provide LGBQ affirmative therapy is an inclusive and affirmative program environment (Carlson et al., 2013; McGeorge & Carlson, 2016; McGeorge et al., 2015, 2018). The hallmarks of an affirmative environment include official program statements that publicly affirm LGBQ communities and communicate an inclusive stance,

policies that appropriately structure student conduct around working with LGBQ communities, and clinical opportunities for working with LGBQ clients (Carlson et al., 2013; McGeorge et al., 2018). To achieve this, it is important that programs actively seek to include the presence of LGBQ students and faculty and ensure that topics and events significant to LGBQ communities are fully integrated into all aspects of the program (Phillips, 1999). Researchers have found that the degree to which programs sustain an LGBQ affirmative environment is related to students' attitudes and competency to provide therapy to clients with marginalized sexual orientations (Carlson et al., 2013).

Challenges of Training Students in LGBQ Affirmative Therapy

The available literature suggests that although training students to work affirmatively with LGBQ clients is essential, it also involves some challenges. One of the challenges is that faculty and students are impacted by larger societal systems of power and oppression that stand in conflict with affirmative work. Several of these have been identified in the literature as barriers to LGBQ affirmative therapy including heterosexism and its effects (e.g., sexual minority prejudice and heterosexual privilege) as well as heteronormative assumptions (Long, 1996; Long & Lindsey, 2004; Matthews, 2007; McCann, 2001; McGeorge & Carlson, 2011). Heterosexism involves two interrelated societal processes: the devaluing and disadvantaging of LGBQ identities and relationships (i.e., sexual minority prejudice) and the simultaneous privileging of heterosexual identities and relationships (Herek, 1990; Ritter & Turndrup, 2002). Heterosexism represents "a form of social control" that establishes and maintains heterosexual dominance (Spaulding, 1999, p. 13). Faculty members are tasked with preparing students to address the negative influence of heterosexism on clients, the therapy process, and on their own lives and relationships (Long, 1996; Long & Lindsey, 2004). Importantly, all faculty and students, regardless of sexual orientation, have been socialized in a heterosexist culture and thus cannot escape the shaping influence that heterosexism has had on their lives. In the face of the explicit oppression and discrimination of LGBQ communities, educators may fail to see the corollary process of heterosexism that positions heterosexuality as superior to all other sexual orientations. For example, with such a pervasive influence, educators may not consider the importance of micro-level acts such as using inclusive language and creating spaces that are welcoming to diverse students and clientele. The ability to not have to consider these so-called small acts of resistance or to ignore the subtle influence of heteronormativity represents just one of the many privileges heterosexual individuals experience.

Relatedly, heteronormative assumptions are a by-product of the positioned superiority of heterosexuality and include the "automatic, unconscious beliefs and expectations that reinforce heterosexuality and heterosexual relationships as the ideal norm" (McGeorge & Carlson, 2011, p. 15). The failure to recognize these unconscious heteronormative assumptions creates reliance on them in faculty and students' personal and professional lives (Oswald et al., 2005). These assumptions may then be unwittingly applied to all identities and relationships in ways that can be harmful to students and, subsequently, their clients. It is therefore important for faculty to not assume that every student and/or client is heterosexual and be open to the possibility that anyone they teach, supervise, or interact with might be a member of an LGBQ community (Matthews, 2007). The first step in decreasing this harm is education that renders heteronormative thoughts conscious and thus available for critique and alteration, even if they may remain automatic. Strategies for beginning this transformative education are discussed in the following section.

Another primary challenge in training students in LGBQ affirmative therapy is the issue of faculty unpreparedness, which may itself be a direct impact of heteronormativity (Corturillo et al., 2016; Long & Serovich, 2003; Phillips, 1999). Although much of the literature appears to assume that faculty already possess the knowledge and skills necessary to prepare students to work with LGBQ clients, researchers have found that students actually report having more

knowledge about LGBQ topics than their faculty members (Phillips & Fischer, 1998). A survey of CFT faculty found that less than half reported receiving any LGBQ affirmative training during their own graduate program (Corturillo et al., 2016). Educators have a responsibility to seek out learning opportunities to increase their knowledge about working with LGBQ clients (Godfrey et al., 2006). This may include continuing education opportunities, attending workshops and webinars focused on LGBQ affirmative therapy, and/or staying up to date with the current literature (Corturillo et al., 2016).

Finally, in keeping with the theme of self-reflection and to contextually situate the following educational strategies, we would like to be transparent about our own intersections of identity. Christi identifies as a heterosexual, cis woman who is actively involved in her Evangelical Lutheran Church in America (ELCA) Lutheran (i.e., a progressive Christian denomination) congregation. Ashley is a bisexual, cisgender woman who holds an appreciation for yogic philosophy and teachings but is not religious. Katelyn identifies as queer, genderqueer, and progressively Christian. Despite our differing intersections, we are all white academics with access to resources and education, and we recognize the immense power inherent in these identities and positions. The strategies presented in the following sections reflect our positionalities and the blind spots our privileges create. Although we encourage open dialogue and elicit feedback from each other and other colleagues, our blind spots inform what we attend to, and fail to attend to, in this chapter. With these limitations in mind, we detail three sets of strategies that faculty might consider in preparing students to provide affirmative therapy, including strategies related to (a) self-of-the-faculty exploration, (b) training and education, and (c) program environment. It is our hope that faculty and students will build on these ideas and transform them to be increasingly intersectional, applied, and just.

Strategies for Self-of-the-Faculty Exploration

Societal expectations and discourses influence everyone and present a barrier for faculty members in their own pursuits to practice LGBQ affirmative therapy. Therefore, a logical first step in preparing students to work with LGBQ clients is self-of-the-faculty work including an exploration of faculty's own beliefs and biases related to sexual orientation. To assist in beginning this important self-of-the-faculty work, we have adapted a three-step self-exploration model originally created to aid heterosexual CFTs in becoming affirmative therapists (McGeorge & Carlson, 2011). The three steps of the model invite an analysis of (a) heteronormative assumptions, (b) heterosexual privileges, and (c) heterosexual identity construction. It is important to acknowledge that the second and third steps are not relevant to all CFT faculty members, but for those who identify as heterosexual these steps are crucial. By including a discussion of heterosexual privilege and identity construction, we do not wish to reinforce the binarization of sexual orientation but instead seek to underscore the responsibility of members of the societally sanctioned, dominant group hold to continually interrogate their beliefs and actions in order to deconstruct systems of power and oppression.

Step 1: Exploring Heteronormative Assumptions

The first step in this self-of-the-faculty work involves a critical reflection of the beliefs that CFT faculty members hold regarding normative and healthy relationship practices. Faculty are invited to acknowledge their own unconscious heteronormative assumptions and to raise their consciousness around the ways these assumptions have shaped their beliefs about sexual orientation, sexuality, and intimate relationships. This awareness process involves examining learned societal and familial messages regarding the normality and superiority of heterosexual relationships and the abnormality and inferiority of LGBQ relationships. Acknowledging the presence of these unconscious heteronormative assumptions is important because it helps CFT faculty members examine

the extent to which heterosexism has shaped their perceptions about LGBQ communities in ways that may go against their personal values and beliefs (Pope, 1995). Faculty can use the self-exploration questions in Table 23.1 to begin the process of bringing these unconscious beliefs to a conscious understanding so they can be interrogated, and thus altered.

Step 2: Exploring Heterosexual Privileges

The second step in this self-of-the-faculty exploration involves heterosexual faculty becoming aware of the privileges that they hold as members of a dominant, socially sanctioned group. Again, although overt discrimination may sometimes be easier to identify, it is important to recognize the inherent connection between marginalization and advantage. Acknowledging the unearned, daily benefits granted to heterosexual people is often a pivotal step in dismantling these systems of power. Faculty can begin this process of acknowledging and dismantling heterosexual privileges by reflecting on the questions found in Table 23.1. In addition, faculty could create their own list detailing the heterosexual privileges that shape their experience and roles as faculty members, supervisors, and therapists. Examples of these privilege statements may include never having to wonder if a colleague, student, and/or client will judge one's sexual orientation; never being accused of promoting a "straight agenda" in the classroom or therapy room; and being able to openly discuss a romantic partner without fear of a negative reaction.

Table 23.1 Self-of-the-Faculty Exploration Questions

Step 1: Exploring heteronormative assumptions
Were sexual orientation and LGBQ relationships talked about in my family of origin? In my community growing up? What about during my own graduate education? If so, what values were communicated? If not, what did that silence communicate?
When a student is reporting information to me about a new client, how often do I assume the client is heterosexual? What values and beliefs inform this assumption?
What was I taught in my family of origin about what healthy and normative relationships look like? How was that reinforced or challenged within my family therapy training? How does that inform how I approach training and supervising students?
Step 2: Exploring heterosexual privileges
How has your involvement in heterosexual relationships been encouraged, rewarded, acknowledged, and supported by your family, friends, society, and academia?
Have you ever worried about your job being at risk, having your work discredited, or being accused of researching too many "heterosexual" topics because of your heterosexuality?
Have you ever worried that your competency as a supervisor might be challenged by students or colleagues based on your heterosexuality?
Have you ever worried that your heterosexuality may become a barrier to being promoted at your current job or hired at a future job? Why or why not?
Step 3: Exploring heterosexual identity construction
What experiences in your life allowed and supported your heterosexual identity?
How do you feel your heterosexual identity has continued to evolve as you move through your academic career? How have your experiences as a supervisor reinforced or challenged this identity?
How has your heterosexual identity informed how you make sense of and relate to clients and students? What areas of safety and power might it grant you?

Note: Regardless of sexual orientation, everyone has been socialized in a heterosexist society and thus may benefit from reflecting on the questions included in Step 1. However, the reflections in Steps 2 and 3 are specific to heterosexual faculty.

Because this chapter is focused on assisting faculty members in training students to provide LGBQ therapy, this discussion of self-of-the-faculty focused on heterosexual privilege as a primary barrier to LGBQ affirmative therapy; however, there are certainly other forms of privilege that faculty members hold, regardless of their sexual orientation. Although beyond the focus of this chapter, we encourage faculty members to also explore the privileges they may hold relating to identity factors such as race, social class, education, and/or gender identity. The questions provided in Table 23.1 may simply be modified by replacing "heterosexuality" with another dominant, privileged identity (e.g., white, upper/middle class, etc.) to begin the process of engaging in this work.

Step 3: Exploring the Construction of a Heterosexual Identity

The third step in this self-of-the faculty exploration involves heterosexual individuals acknowledging that they have a sexual orientation and exploring how they came to identify with that sexual orientation (McGeorge & Carlson, 2011). Research examining the identity construction of heterosexual individuals began as an effort to highlight that all people have a sexual orientation, not simply those who are marginalized (Mohr, 2002; Worthington et al., 2002). Recognizing this has the potential to lead to increased awareness of one's own heteronormative assumptions and heterosexual privilege. For example, when heterosexual therapists explore the construction of their heterosexual identity, they tend to have greater acceptance of all sexual orientations and report a reduced reliance on heteronormative assumptions (Dillon et al., 2004). A list of questions that heterosexual faculty members may find helpful as they begin to explore the construction of their heterosexual sexual orientation can be found in Table 23.1. This process is important because it "appropriately shifts the focus from exclusively examining the identity development of the marginalized group to examining the identity development of the dominant, socially-sanctioned group" (McGeorge & Carlson, 2011, p. 6).

There are several ways that CFT faculty could use the self-reflection questions associated with each of these three steps. Faculty might consider these questions on their own using a critical journaling process. They could also identify an accountability partner with whom they can be honest in acknowledging the ways heterosexism has influenced their personal and professional lives. Faculty members may also want to explore these self-reflection questions together during a faculty meeting or retreat. Finally, these ideas can be discussed on a larger scale in program meetings with students.

Case Study: Self-of-the-Faculty

Keisha, a second-year master's student, is working with an adolescent in individual therapy. The adolescent recently confided to Keisha that she thinks she is a pansexual. Keisha brings this case to group supervision, led by Sebastian. Sebastian explains to Keisha that it is important that Keisha tell her client's parents that their daughter is pansexual so that they can support her through the coming out process. Sebastian also directs Keisha to develop a therapy goal focused on her client disclosing her sexual orientation at school, so she can "start living congruently and feeling better about herself." Keisha is uncomfortable with both of these suggestions, as she knows from her own coming out process that it took several years before she was ready to tell her parents, and she did not feel safe coming out in her own high school. Keisha does not know how to respond to her supervisor and fears she will be seen as challenging authority. Questions for reflection:

- What steps can Sebastian take to be more mindful of his power in order to increase the likelihood that Keisha can raise her concerns? How might he reconsider his position as an authority figure in this context and remain open to the experiences of LGBQ supervisees when conceptualizing cases?

- What heteronormative assumptions might be guiding Sebastian's recommendations and failure to consider safety and autonomy?
- Sebastian identifies as heterosexual and cisgender. What self-of-the-faculty member work might be helpful to Sebastian?

Strategies for Training and Education

A second focus of the literature on LGBQ affirmative therapy is training and educational strategies to prepare students to work with clients who hold marginalized sexual orientations. These strategies can be divided into three main sections, suggestions for: (a) course content, (b) assignments, and (c) class activities. Prior to discussing these three components of CFT training, it is important to acknowledge that a key aspect of preparing students to become LGBQ affirmative therapists includes increasing their sociopolitical awareness, teaching advocacy skills, and developing students' awareness that advocacy is a core competency of CFT practice (Dillon et al., 2004; McGeorge & Carlson, 2010).

Increasing students' sociopolitical awareness involves teaching them about the history of LGBQ people's struggles for basic civil rights (e.g., housing, employment, and marriage equality). This is increasingly important as many of these struggles continue to occur on the state and federal levels, leaving LGBQ individuals positioned between both gains and threats to social equity. Because many of the struggles experienced by LGBQ individuals stem from living in a heterosexist society, CFT faculty need to teach students how to effectively advocate for their LGBQ clients both inside and outside the therapy room. This could involve teaching students the skills necessary to engage in personal, political, and professional advocacy. Personal advocacy may include challenging heteronormative language in conversations with family and friends, whereas political advocacy may involve supporting legislation that expands the civil rights of LGBQ communities. Finally, professional advocacy might involve writing letters to the AAMFT board to encourage the organization to label the practice of sexual orientation change efforts as unethical and a violation of the AAMFT Code of Ethics (McGeorge & Carlson, 2010).

Effective advocacy also involves teaching students to be aware of resources within the local community that serve and support LGBQ individuals, relationships, and families. These resources can help clients confront the isolation that may be associated with belonging to a marginalized group (Bernstein, 2000; Long & Serovich, 2003). Faculty will want to remain aware of differential experiences of advocacy, in all its forms, for heterosexual and LGBQ students. In most circumstances, heterosexual students will experience less risk, emotionally and perhaps physically, when engaging in advocacy due to the safety that comes with their privileged position. At the same time, LGBQ students may have lived experiences and insider knowledge about both struggles and resources in the community that enhance their advocacy skills. It may also be that students identify with a heterosexual identity at one point in their education and with an LGBQ identity at another. With this in mind, it is important for faculty to embrace the fluidity of identity in that experiences of advocacy can shift with the salience and timeframe of one's experience of identity. It is also important to consider the contexts that advocacy takes place within. One's social location as well as one's physical presentation can influence both the experience of doing the advocacy work and the outcome. Ultimately, CFT faculty should honor the agency of LGBQ students to make advocacy decisions that are in their best interest.

Course Content

This section focuses on topics that need to be addressed in academic courses to prepare CFT students to provide LGBQ affirmative therapy. Before discussing specific topics, a general suggestion is to include information on issues relevant to working with LGBQ clients in each and

every course (Long, 1996; Long & Serovich, 2003). The literature also highlights the need to include readings that explore the heterosexist biases that exist in the foundational theoretical approaches of the field (Matthews, 2007; Phillips, 1999). In addition to increased awareness of historical biases within CFT, this section offers examples of how to integrate LGBQ affirmative therapy content into four areas of the curriculum: (a) diagnosis and assessment, (b) ethics, (c) research methods, and (d) lifespan development.

Diagnosis and Assessment An important element to any diagnosis and assessment class is a critical analysis of the heterosexist biases that exist in diagnosis and assessment processes, as well as in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). In addition, faculty members may wish to situate the difficulties of LGBQ clients within the influences of heterosexism, minority-related stress, and a history of oppression and invisibility (Phillips, 1999). For example, existing research documents that LGBQ individuals experience increased rates of depression and anxiety as well as alcohol and drug misuse (Lewis et al., 2003; NIDA, 2017). However, minority-related stress (i.e., the additional stress that LGBQ individuals experience due to marginalization) appears to be the cause of these increased rates of internalizing symptoms and substance abuse-related coping (Meyer, 1995). Thus, it is essential for faculty to teach students about the role that minority-related stress plays in the emotional and relational experiences of LGBQ individuals.

Ethics It is important to integrate the unique ethical considerations related to working with LGBQ clients throughout clinical ethics courses. A central topic is the unethical nature of sexual orientation change efforts (SOCE) and the research that illustrates its damaging effects on LGBQ clients (Greene, 2007; Serovich et al., 2008). SOCE is based on the belief that LGBQ sexual orientations are pathological and/or immoral, thereby "[violating] principles of competence, integrity, respect for individual rights and dignity, and social responsibility" (Serovich et al., 2008, p. 235). Faculty might utilize the AAMFT board's position on the practice of SOCE as an important reference to address these concerns; it states that the AAMFT "does not consider homosexuality a disorder that requires treatment, and as such, we see no basis for such therapy" (AAMFT, 2009). To further this discussion, faculty members could incorporate data on state-level legislation banning the practice of SOCE with minors (Movement Advancement Project, 2019).

Another important topic for faculty to integrate into ethics courses is a discussion of CFTs refusing to see LGBQ clients and making referrals based solely on the clients' sexual orientation (McGeorge et al., 2016). This "practice" violates the non-discrimination clause in the code of ethics as it represents refusing to work with a client based on a protected identity. Notably, such a referral would not be allowed if it were based on another demographic factor such as race or socio-economic status (Kaplan, 2014; McGeorge et al., 2016). Such a discriminatory referral poses great potential harm to LGBQ clients as it is another form of rejection that may mirror their experiences with friends, family members, and/or employers (Shiles, 2009).

Finally, faculty also need to include content on other legal factors that may pose unique challenges to LGBQ relationships and families. These content areas include laws regulating adoption, parental rights, the use of sperm donors and surrogates, and state and federal discrimination protections in housing and employment. In this way, ethics education may serve to increase students' awareness of laws that both harm and protect LGBQ individuals, relationships, and families.

Research Methods The literature on LGBQ affirmative training highlights the need to include LGBQ topics in research methods courses (Anhalt et al., 2003; Phillips, 1999). One way faculty might do this is by using published studies on LGBQ topics to illustrate various methodologies and/or research designs (Anhalt et al., 2003). Simply including research on social justice topics as exemplars increases exposure to these important topics. Faculty might also introduce queer

theory and other critical social theories as potential research methodologies and guiding theoretical lenses. Queer theory methodologies can provide an effective mechanism to de-center traditional heteronormative assumptions that are present in many existing approaches to research (Oswald et al., 2005).

Lifespan Development In addition to clinical and research courses, content on LGBQ individuals and families should be integrated into lifespan development courses so CFTs are prepared to work with LGBQ clients across the lifespan (Greene, 2007). For example, therapists who are open to the possibility that children may have diverse sexual orientations will be more prepared to approach work with youth in anti-heterosexist ways. This may include acknowledging the effects of feeling different from peers or isolated from family. Information about LGBQ parents can also be included, especially as it relates to queer-socialization of children. Specifically, therapists should be aware of conversations LGBQ parents may have with their children about navigating systems of discrimination and/or how their family structure may differ from their peers. Course content could focus on these topics as well as skills for facilitating queer-socialization conversations with LGBQ families utilizing an ecological approach.

Course Assignments

Integrating LGBQ affirmative course assignments is another pragmatic way to prepare students to work with clients who hold marginalized sexual orientations. One of the primary purposes of these assignments is to help facilitate the process of students exploring their own heteronormative assumptions and, if applicable, heterosexual privilege. Through writing, students can reflect on the contextual factors that influenced the construction of their sexual orientations, how their intersectional identities may differ from their clients, and how to create plans to acknowledge and reduce their heteronormative biases. Students can also be tasked with writing an LGBQ affirmative statement, articulating their commitment to practicing affirmative therapy, and outlining specific practices they will utilize (McGeorge & Carlson, 2010). Finally, writing assignments are a productive way to assist students in developing their advocacy skills. For example, students could write to the AAMFT or their state professional organizations calling for the adoption of policies and/or statements indicating support for LGBQ civil rights. Students could also be given the option to write letters to the editor or op-eds supporting the rights of LGBQ individuals, couples, and families.

Along with self-reflective and advocacy-related writing tasks, assignments can also be used to increase student exposure to the lives and relationships of LGBQ individuals. For example, faculty can assign students to review books or other media (e.g., movies, television series) featuring LGBQ protagonists (Long & Serovich, 2003; Matthews, 2007). Such media can be used to increase exposure to the "everyday experiences" of LGBQ individuals and families (Green, 1996). Media-related assignments, such as film analysis, can also provide students with the opportunity to analyze a storyline using a particular theory or critical lens.

Course Activities

In addition to assignments, course activities can help prepare students to provide LGBQ affirmative therapy. For example, within the classroom, students can engage in role plays to practice the skills associated with affirmative therapy prior to working with clients (Godfrey et al., 2006; Long & Serovich, 2003). Video clips can be used to simulate potential client situations such as navigating experiences of heterosexism or peer rejection. Students working in small groups could develop and present treatment plans for affirmative work with LGBQ clients in these situations and discuss the successes and challenges of varying approaches (Green, 1996). Faculty could also invite LGBQ therapists to guest lecture or to participate in a panel discussion about issues relevant to working with LGBQ clients (Godfrey et al., 2006; Long & Serovich, 2003).

As always, activities do not need to be restricted to the classroom (Matthews, 2007). In fact, because part of LGBQ affirmative therapy includes developing positive beliefs about LGBQ people, some of the best learning opportunities can occur in the community. Students can be encouraged to attend events or activities where LGBQ people are present to increase personal contact. These personal interactions can serve to both decrease heterosexist biases and increase commitment to engaging in advocacy. Importantly, clients should not be the only mechanism for contact with LGBQ individuals. Instead, students can become involved in LGBQ communities through activities such as marching in a local pride parade as part of a group of affirmative therapists (Matthews, 2007). CFT faculty may need to emphasize that any opportunities for students to become involved in their local LGBQ communities are not meant to be appropriative; rather, contact with LGBQ communities must be about appreciation and respect. Finally, faculty should be mindful that LGBQ students are likely to be present in their classes and that these students may already be actively involved with LGBQ communities.

Case Study: Training and Education

Clara has been a faculty member for five years in an accredited, combined master's and doctoral program. Her students and colleagues have met her wife at program social events, and Clara has felt largely supported during her academic career. One day following her couple's therapy class, Clara hears one of her students make a comment to another classmate: "Why do we have to read all of these articles about queer couples? Can't we just learn about normal couples?" Clara worries that her students and colleagues will perceive her as "pushing an agenda" even though she is aware that the readings on LGBQ couples and families make up only a small fraction of the assigned chapters and articles for her course. She wonders what she should do and how she should approach her student in a way that helps the student appreciate the importance of learning about many kinds of partnerships. Questions for reflection:

- How does your experience of this case study change if Clara is a person of color or white? Non-binary or cisgender? An international faculty or U.S.-born? Specifically consider how the intersecting dynamics related to power and identity influence the professor and student relationship in addition to the faculty member's sense of agency to respond.
- What are Clara's options for approaching this conversation with her student? How do the intersections presented above influence these options?
- What steps could the faculty within this program take related to course content and how this content is integrated?

Strategies for Creating an LGBQ Affirmative Program Environment

Perhaps the most important way to prepare students to become LGBQ affirmative therapists is for CFT programs to develop and implement affirmative policies and practices (Carlson et al., 2013). Indeed, researchers have found that an LGBQ affirmative environment in clinical agencies is associated with therapists' ability to practice affirmative therapy (Bieschke & Matthews, 1996; Matthews et al., 2005). Here we review several elements in the development of an LGBQ affirmative program environment: (a) assessment, (b) program polices, (c) on-site clinic, and (d) recruitment.

Assessment

CFT programs could consider conducting an initial assessment to begin the process of structuring an LGBQ affirmative program environment. Long and Serovich (2003) offer a series of

assessment questions to examine the program training environment and identify areas where they can become more LGBQ affirmative: "Is our program adequately inclusive of sexual minority training materials?" "What struggles do we experience in cultivating an inclusive environment?" and "Would gay, lesbian, and bisexual trainees feel comfortable disclosing their sexual orientation within the environment of this program?" (p. 60). When considering these questions, it is important that this assessment process goes beyond the perspectives of faculty and accounts for multiple perspectives including current students, alumni, students who chose to not accept admission into the program, and clients. Throughout this process, it is crucial that faculty take a humble stance in inquiring about students' safety and remain open to LGBQ students' feedback. Programs might also consider developing an anonymous exit survey to assess the degree to which the program is fostering an LGBQ affirmative environment, as current students may not feel they have the power to speak up without consequence (McGeorge & Carlson, 2016). Finally, advisory boards made up of members of local LGBQ communities could provide feedback on the program environment including suggestions for creating greater safety, inclusion, and learning opportunities (McGeorge & Carlson, 2016).

Policies

There are a number of policies that CFT programs need to implement and publicize in their student handbook, and on their program website, to create and maintain an LGBQ affirmative environment. Programs could develop a policy outlining the program's affirmative stance that includes a clear expectation that students practice affirmatively, in addition to anti-discrimination and harassment policies banning the use of homophobic language and behaviors (Long & Serovich, 2003). Such a policy might include a statement of commitment to preparing students to competently serve LGBQ clients and procedures for responding to situations when students do not hold affirmative beliefs, which impacts their ability to practice affirmatively (Long & Serovich, 2003).

On-Site Clinic

Training programs that have an on-site clinic should ensure that their intake forms use open-ended questions when inquiring about clients' sexual orientation, gender identity, and relationship status. Additionally, informed consent documents can be updated to note that disclosures related to sexual orientation will be kept confidential (Long & Serovich, 2003). It is also important that clinic advertising materials contain a non-discrimination statement that specifically includes sexual orientation, in addition to including images of LGBQ people in their clinic marketing materials (Matthews, 2007). Waiting rooms can be made more welcoming and inclusive by providing magazines and other resources serving LGBQ communities (Long & Serovich, 2003; Matthews, 2007). Finally, faculty might partner with local agencies that serve LGBQ communities in order to actively recruit LGBQ clients and ensure students gain this valuable clinical experience (Long & Serovich, 2003).

Recruitment

In addition to actively recruiting LGBQ clients, CFT programs need to develop specific strategies to recruit and retain LGBQ students. Programs could send recruitment materials locally, regionally, and nationally to LGBQ studies programs, campus LGBQ student service centers, and other university organizations that serve LGBQ students. Programs might also consider advertising through listservs or websites focused on LGBQ scholarship and advocacy. Recruitment materials could highlight the program's commitment to affirmative training, involvement in LGBQ events or activities, and research on LGBQ topics by faculty and students (Phillips, 1999).

Finally, it is essential for faculty to recognize that, due to living in a heterosexist society, it is impossible for programs to ever arrive at a place where they are fully affirmative. Therefore,

CFT programs will need to humbly engage in a recursive process of continual evaluation of their policies, processes, structures, and overall environment (Phillips, 1999). With this in mind, programs may consider asking members of local LGBQ communities to conduct annual evaluations of the program, in addition to the ongoing assessment procedures described above.

Case Study: LGBQ Affirmative Program Environment

Ben, a second-year master's student, recently received a new case that he is bringing to individual supervision with his supervisor, Henry. Ben explains that his new case consists of a gay male couple who has come to work through their grief surrounding the recent death of one partner's mom. Ben shares that although he feels comfortable doing the grief and loss work, there are elements of the case with which he is not comfortable. When Henry asks about the discomfort, Ben shares that, as a Christian, he believes gay relationships are sinful and immoral. Ben states that he would not be willing to work with a gay couple on topics directly related to their relationship, and that he plans only to discuss the couple's grief. Questions for reflection:

- How does your experience of this case study change if Ben is a person of color or white? A woman or a man? An international student or U.S.-born? Specifically consider how the intersecting dynamics related to power and identity influence the supervisor and supervisee relationship.
- What programmatic policies might help address this circumstance with Ben?
- What important topics will Henry need to talk with Ben about in supervision, and how might these change (if at all) based on different intersections of identity (such as the ones above) for both Ben and Henry?

Conclusion and Future Directions

The available literature clearly documents the need for CFT programs to prepare students to provide skillful and just therapy services to LGBQ clients. The LGBQ affirmative training process starts with faculty's commitment to engaging in their own self-reflective journeys to address the influence of heterosexism on their personal and professional lives. This chapter provides self-reflection questions to begin this process, strategies for the inclusion of LGBQ course content, and ideas to create and maintain an affirmative program environment.

Future directions of LGBQ affirmative training are grounded in a clear need for intersectional awareness that fosters a commitment to justice and equity. Scholars are increasingly acknowledging the broad range of gender identities and sexual orientations, including those not centered in the gender binary, and relationships that are not limited by the bounds of "couplehood." Affirmative therapy will need to continue to promote movements to end the oppression of people with marginalized identities by acknowledging that affirmative clinical work is not a "political issue" but rather "a matter of ethics, standard of care, and psychotherapy effectiveness" (Brown, 1996, p. 54). LGBQ affirmative therapy and training is a life-long, recursive journey through which no one will ever fully arrive. Inspired by our clients and colleagues, we invite the CFT field to join us on this journey to stand against the power of heterosexism and the oppression of LGBQ people.

References

American Association for Marriage and Family Therapy. (2009). *Reparative/conversion therapy.* https://www.aamft.org/About_AAMFT/Position_On_Couples.aspx?WebsiteKey=8e8c9bd6-0b71-4cd1-a5ab-013b5f855b01

Anhalt, K., Morris, T. L, Scotti, J. R., & Cohen, S. H. (2003). Student perspectives on training in gay, lesbian, and bisexual issues: A survey of behavioral clinical psychology programs. *Cognitive and Behavioral Practice, 10*(3), 255–263. https://doi.org/10.1016/S1077-7229(03)80038-X

Bernstein, A. C. (2000). Straight therapists working with lesbians and gays in family therapy. *Journal of Marital and Family Therapy, 26*(4), 443–454. https://doi.org/10.1111/j.1752-0606.2000.tb00315.x

Bieschke, K. J., & Matthews, C. R. (1996). Career counselor attitudes and behaviors toward gay, lesbian, and bisexual clients. *Journal of Vocational Behavior, 48*(2), 243–255. https://doi.org/10.1006/jvbe.1996.0021

Brown, L. (1996). Preventing heterosexism and bias in psychotherapy and counseling. In E. D. Rothblum & L. A. Bond (Eds.), *Preventing heterosexism and homophobia* (pp. 36–58). Sage.

Carlson, T. S., McGeorge, C. R., & Toomey, R. B. (2013). Establishing the validity of the affirmative training inventory: Assessing the relationship between lesbian, gay, and bisexual affirmative training and students' clinical competence. *Journal of Marital and Family Therapy, 39*(2), 209–222. https://doi.org/10.1111/j.1752-0606.2012.00286.x

Coburn, K. O., & McGeorge, C. R. (2019). What do Christian clergy say? Advice from Christian pastors to family therapists about working with LGB clients. *Contemporary Family Therapy: An International Journal, 41*(3), 236–246. https://doi.org/10.1007/s10591-019-09490-0

Cochran, S. D., Sullivan, J. G., & Mays, V. M. (2003). Prevalence of mental disorders, psychological distress, and mental health services use among lesbian, gay, and bisexual adults in the United States. *Journal of Consulting and Clinical Psychology, 71*(1), 53–61. https://doi.org/10.1037/0022-006X.71.1.53

Corturillo, E. M., McGeorge, C. R., & Carlson, T. S. (2016). How prepared are they? Exploring couple and family therapy faculty members' training experiences in lesbian, gay, and bisexual affirmative therapy. *Journal of Feminist Family Therapy, 28*(2–3), 55–75. https://doi.org/10.1080/08952833.2016.1179549

Crenshaw, K. W. (1989). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory, and antiracist politics. *University of Chicago Legal Forum, 189,* 139–167.

Davies, D. (2000). Towards a model of gay affirmative therapy. In D. Davies & C. Neal (Eds.), *Pink therapy: A guide for counselors and therapists working with lesbian, gay, and bisexual clients* (pp. 24–40). Open University Press.

Diamond, L. M. (2016). Sexual fluidity in male and females. *Current Sexual Health Reports, 8*(4), 249–256. https://doi.org/10.1007/s11930-016-0092-z

Dillon, F. R., Worthington, R. L., Savoy, H. B., Rooney, S. C., Schutte, A. B., & Guerra, R. M. (2004). On becoming allies: A qualitative study of lesbian-gay-and-bisexual affirmative counselor training. *Counselor Education and Supervision, 43*(3), 162–178. https://doi.org/10.1002/j.1556-6978.2004.tb01840.x

Dworkin, S. H., & Gutierrez, F. (1989). Introduction to special issue. Counselors be aware: Clients come in every size, shape, color, and sexual orientation. *Journal of Counseling and Development, 68*(1), 6–8. https://doi.org/10.1002/j.1556-6676.1989.tb02483.x

Edwards, L. L., Robertson, J. A., Smith, P. M., & O'Brien, N. B. (2014). Marriage and family training programs and their integration of lesbian, gay, and bisexual identities. *Journal of Feminist Family Therapy, 26*(1), 3–27. https://doi.org/10.1080/08952833.2014.872955

Godfrey, K., Haddock, S. A., Fisher, A., & Lund, L. (2006). Essential components of curricula for preparing therapists to work with lesbian, gay, and bisexual clients: A Delphi study. *Journal of Marital and Family Therapy, 32*(4), 491–504. https://doi.org/10.1111/j.1752-0606.2006.tb01623.x

Green, R. J. (1996). Why ask, why tell? Teaching and learning about lesbians and gays in family therapy. *Family Process, 35*(3), 389–400. https://doi.org/10.1111/j.1545-5300.1996.00389.x

Greene, B. (2007). Delivering ethical psychological services to lesbian, gay, and bisexual clients. In K. J. Bieschke, R. M. Perez, & K. A. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, bisexual, and transgender clients* (2nd ed., pp. 181–199). American Psychological Association.

Grzanka, P. R., & Miles, J. R. (2016). The problem with the phrase "intersecting identities": LGBT affirmative therapy, intersectionality, and neoliberalism. *Sexuality Research and Social Policy, 13*(4), 371–389. https://doi.org/10.1007/s13178-016-0240-2

Hartwell, E. E., Serovich, J. M., Grafsky, E. L., & Kerr, Z. Y. (2012). Coming out of the dark: Content analysis of articles pertaining to gay, lesbian, and bisexual issues in couple and family therapy journals. *Journal of Marital and Family Therapy, 38*(s1), 227–243. https://doi.org/10.1111/j.1752-0606.2011.00274.x

Henke, T., Carlson, T. S., & McGeorge, C. R. (2009). Homophobia and clinical competency: An exploration of couple and family therapists' beliefs. *Journal of Couple & Relationship Therapy, 8*(4), 325–342. https://doi.org/10.1080/15332690903246101

Herek, G. M. (1990). The context of anti-gay violence: Notes on cultural and psychological heterosexism. *Journal of Interpersonal Violence, 5*(3), 316–333. https://doi.org/10.1177/088626090005003006

Kaplan, D. M. (2014). Ethical implications of a critical legal case for the counseling profession: *Ward v. Wilbanks. Journal of Counseling and Development, 92*(2), 142–146. https://doi.org/10.1002/j.1556-6676.2014.00140.x

Lewis, R. J., Derlega, V. J., Griffin, J. L., & Krowinski, A. C. (2003). Stressors for gay men and lesbians: Life stress, gay-related stress, stigma consciousness, and depressive symptoms. *Journal of Social and Clinical Psychology, 22*(6), 716–729. https://doi.org/10.1521/jscp.22.6.716.22932

Long, J. K. (1996). Working with lesbians, gays, and bisexuals: Addressing heterosexism in supervision. *Family Process, 35*(3), 377–388. https://doi.org/10.1111/j.1545-5300.1996.00377.x

Long, J. K., & Lindsey, E. (2004). The sexual orientation matrix for supervision: A tool for training therapists to work with same-sex couples. *Journal of Couple & Relationship Therapy, 3*(2–3), 123–135. https://doi.org/10.1300/J398v03n02_12

Long, J. K., & Serovich, J. M. (2003). Incorporating sexual orientation into MFT training programs: Infusion and inclusion. *Journal of Marital and Family Therapy, 29*(1), 59–67. https://doi.org/10.1111/j.1752-0606.2003.tb00383.x

Matthews, C. R. (2007). Affirmative lesbian, gay, and bisexual counseling with all clients. In K. J. Bieschke, R. M. Perex, & K. A. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, bisexual, and transgender clients* (2nd ed., pp. 201–219). American Psychological Association.

Matthews, C. R., Selvidge, M. M. D., & Fisher, K. (2005). Addiction counselors' attitudes and behaviors toward gay, lesbian, and bisexual clients. *Journal of Counseling & Development, 83*(1), 57–65. https://doi.org/10.1002/j.1556-6678.2005.tb00580.x

McCann, D. (2001). Lesbians, gay men, their families and counselling: Implications for training and practice. *Educational and Child Psychology, 18*(2), 78–88.

McGeorge, C. R., & Carlson, T. S. (2010). Social justice mentoring: Preparing family therapists for social justice advocacy work. *Michigan Family Review*, *14*(1), 42–59. https://doi.org/10.3998/mfr.4919087.0014.106

McGeorge, C. R., & Carlson, T. S. (2011). Deconstructing heterosexism: Becoming an LGB affirmative heterosexual couple and family therapist. *Journal of Marital and Family Therapy, 37*(1), 14–26. https://doi.org/10.1111/j.1752-0606.2009.00149.x

McGeorge, C. R., & Carlson, T. S. (2016). The state of lesbian, gay, and bisexual affirmative training: A survey of faculty from accredited couple and family therapy programs. *Journal of Marital and Family Therapy, 42*(1), 153–167. https://doi.org/10.1111/jmft.12106

McGeorge, C. R., Carlson, T. S., & Farrell, M. (2016). To refer or not to refer: Exploring family therapists' beliefs and practices related to the referral of LGB clients. *Journal of Marital and Family Therapy, 42*(3), 466–480. https://doi.org/10.1111/jmft.12148

McGeorge, C. R., Carlson, T. S., & Toomey, R. B. (2015). Assessing lesbian, gay, and bisexual affirmative training in couple and family therapy: Establishing the validity of the faculty version of the Affirmative Training Inventory. *Journal of Marital and Family Therapy, 41*(1), 57–71. https://doi.org/10.1111/jmft.12054

McGeorge, C. R., Kellerman, J., & Carlson, T. S. (2018). Indicators of LGB affirmative training: An exploratory study of family therapy faculty members. *Journal of Feminist Family Therapy, 30*(1), 1–24. https://doi.org/10.1080/08952833.2017.1381825

Meyer, I. (1995). Minority stress and mental health in gay men. *Journal of Health and Social Behavior, 36*(1), 38–56. https://doi.org/10.2307/2137286

Mohr, J. J. (2002). Heterosexual identity and the heterosexual therapist: An identity perspective on sexual orientation dynamics in psychotherapy. *The Counseling Psychologist, 30*(4), 532–566. https://doi.org/10.1177/00100002030004003

Movement Advancement Project. (2019). *Conversion therapy laws*. http://www.lgbtmap.org/equality-maps/conversion_therapy

NIDA. (2017, September 5). *Substance use and SUDs in LGBT populations*. https://www.drugabuse.gov/related-topics/substance-use-suds-in-lgbt-populations

Oswald, R. F., Blume, L. B., & Marks, S. R. (2005). Decentering heteronormativity: A model for family studies. In V. L, Bengtson, A. C. Acock, K. R. Allen, P. Dilworth-Anderson, & D. M. Klein (Eds.), *Sourcebook of family theory & research* (pp. 143–165). Sage.

Oswalt, S. B., Evans, S., & Drott, A. (2016). Beyond alphabet soup: Helping college health professionals understand sexual fluidity. *Journal of American College Health, 64*(6), 502–508. https://doi.org/10.1080/07448481.2016.1170688

Phillips, J. C. (1999). Training issues and considerations. In R. M. Perez, K. A. DeBord, & K. J. Bieschke (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients* (pp. 337–358). American Psychological Association.

Phillips, J. C., & Fischer, A. R. (1998). Graduate students' training experiences with lesbian, gay, and bisexual issues. *The Counseling Psychologist, 26*(5), 712–734. https://doi.org/10.1177/0011000098265002

Pope, M. (1995). The "salad bowl" is big enough for us all: An argument for the inclusion of lesbians and gay men in any definition of multiculturalism. *Journal of Counseling and Development, 73*(3), 301–304. https://doi.org/10.1002/j.1556-6676.1995.tb01752.x

Ritter, K. Y., & Turndrup, A. I. (2002). *Handbook of affirmative psychotherapy with lesbians and gay men.* Guilford.

Rock, M., Carlson, T. S., & McGeorge, C. R. (2010). Does affirmative training matter? Assessing CFT students' beliefs about sexual orientation and their level of affirmative training. *Journal of Marital and Family Therapy, 36*(2), 171–184. https://doi.org/10.1111/j.1752-0606.2009.00172.x

Serovich, J. M., Craft, S. M., Toviessi, P., Gangamma, R., McDowell, T., & Grafsky, E. L. (2008). A systematic review of the research base on sexual reorientation therapies. *Journal of Marital and Family Therapy, 34*(2), 277-238. https://doi.org/10.1111/j.1752-0606.2008.00065.x

Shiles, M. (2009). Discriminatory referrals: Uncovering a potential ethical dilemma facing practitioners. *Ethics and Behavior, 19*(2), 142–155. https://doi.org/10.1080/10508420902772777

Spaulding, E. C. (1999). Unconsciousness-raising: Hidden dimensions of heterosexism in theory and practice with lesbians. In J. Laird (Ed.), *Lesbians and lesbian families: Reflections of theory and practice* (pp. 11–26). Columbia University Press.

Worthington, R. L., Savoy, H. B., Dillon, F. R., & Vernaglia, E. R. (2002). Heterosexual identity development: A multidimensional model of individual and social identity. *The Counseling Psychologist, 30*(4), 496–531. https://doi.org/10.1177/00100002030004002

24
Self-Disclosure
Considerations for Therapy and Supervision

STEPH COOKE, MARY R. NEDELA, DARAN SHIPMAN, and ERIKA L. GRAFSKY

Self-disclosure is defined as the process of revealing personal details about the therapist to clients (Barnett, 2011). Prior to revealing these personal details, it is important to understand how such disclosures can impact the individuals we work with. The research on self-disclosure in therapy and supervision is varied. When utilized as a joining technique, there is evidence that self-disclosure can build a sense of connection and trust with clients and therefore aid in the development of therapeutic relationships (Pettyjohn et al., 2019; Roberts, 2005). However, some research suggests that disclosure can potentially take the focus of treatment away from clients (Kelly & Rodriguez, 2007; Knight, 2012), and because of this possibility, it is important for therapists to be intentional in what they disclose and strategic in how they disclose.

Supervisors are most often tasked with helping therapists navigate self-disclosure both in supervision and with their clients. The existing literature highlights the importance of a positive supervisory relationship. According to Staples-Bradley et al. (2019), the evaluative nature of the supervisory relationship may be a potential barrier to self-disclosure. It has been found that students and supervisees often avoid discussing sensitive topics with their supervisor (Knight, 2014; Pisani, 2005). A lack of trust, or fears of being evaluated negatively, may prevent the therapist from self-disclosing critical information. Ultimately, this could raise liability concerns for supervisors (Pisani, 2005) and be a missed opportunity for the supervisee to develop skills involved in clinical judgment (Solo, 2019; Staples-Bradley et al., 2019). The available literature emphasizes components of an effective supervisory relationship, one of which is a supervisor's willingness to model the skill of self-disclosure that may facilitate open and safe discussion (Knight, 2014; Pisani, 2005; Solo, 2019; Staples-Bradley et al., 2019).

This chapter focuses exclusively on sexual and gender identity disclosure in therapy and in supervision with an emphasis on protecting the alliances with clients, supervisor, and supervisees. We present these concepts through a sociopolitical lens. In order to understand self-disclosure of sexual and gender identity in therapy settings, we must first recognize how diverse sexual and gender identities are situated within the larger cultural context and structures of society.

The Larger Structures That Support Heteronormativity and Cisnormativity

In 2015, the U.S. Supreme Court made same-sex marriage legal in all 50 states. This demonstrates increased support for LGBTQ+ identities; however, the society in which we are a part continues to be heavily influenced by heteronormative ideologies (Shelton & Delgado-Romero, 2011). The term "heteronormativity" has been used widely since its introduction by queer and feminist scholars. There is no consistent definition of the word; however, a content analysis by Marchia and Sommer (2019) revealed some common themes. Heteronormativity is likely often used to describe the privilege and power that individuals who identify as heterosexual have, which in turn is supported by larger systems within their society (Marchia & Sommer, 2019). Heteronormativity includes the performance of patriarchal norms that reinforce heterosexuality

DOI: 10.4324/9780429274626-30

as the dominant identity. Simoni (2001) expanded on this by stating, "the privilege of heterosexuals includes marriage, custody, and adoption rights; tax and insurance benefits; anti-discrimination protection in housing and employment; and benefits and protections in terms of military service, inheritance, hospital visitation, pensions, and immigration" (p. 158). These performances may be identifiable in the inner relational networks that we are a part of as well (e.g., family members, friends, colleagues, neighbors, clients, and supervisees). One's ability to be visible as a heterosexual individual, in micro- and macro-systems, is supported by heteronormativity. In contrast, LGBTQ+ individuals report egregious acts of hostility and even violence for simply existing as a person that society deems inferior (McCabe et al., 2013; Nagoshi et al., 2008). This is particularly true for transgender and gender expansive people who must also exist within a cisnormative system (Pyne, 2011).

A cisnormative system is "one in which people are assumed to be cissexual [or cisgender]" (Bauer et al., 2009, p. 353). A cisgender identity is one in which a person's sex assigned at birth and gender identity align (Tate, 2013). In contrast, transgender and gender expansive people are "individuals whose gender identity or expression does not align with their sex assigned at birth" (Chodzen et al., 2019, p. 467). The privilege afforded to cisgender people is demonstrated in the ability to be visible as a cisgender male or cisgender female without fear for one's safety when it comes to gender expression and gender identity (Hill & Willoughby, 2005). In comparison to the rest of the U.S. population, transgender and gender expansive individuals face a higher risk of sexual violence within their lifetime compared to all cisgender individuals (Matsuzaka & Koch, 2018; Stotzer, 2009). This risk is heightened for transgender individuals of color (Follins et al., 2014; Graham, 2014). Reports of violence or victimization experienced by transgender and gender expansive people is well documented in self-report surveys, hotline calls to advocacy groups, and police reports (Stotzer, 2009). Stotzer's (2009) review of the data shows a significant need to understand the different contexts in which transgender and gender expansive individuals live. As supervisors, therapists, and researchers, it is our responsibility to stay updated on best practices to support this population.

It is critical to become familiar with the oppression sexual and gender minorities face, as well as the potential impact of disclosing these identities in therapy and supervision. This also includes self-awareness regarding how therapy and therapists play a role in perpetuating an oppressive system. In my experience (SC), I have noticed that my own lack of education or silence on some issues, such as the intersection of gender and sexuality, is the ultimate unintentional way of choosing the side of the oppressor. Although I (SC) identify as a bisexual Black woman, I must continue to be informed on issues that impact others with an LGBTQ+ identity who may or may not share my experience. This is an ongoing task that even the most well-intentioned therapists must face. From a social justice perspective, it is important to be self-aware of biases or blind spots (Diaz et al., 2019) and to challenge them.

Addressing one's negative beliefs, biases, and assumptions regarding sexual and gender identities is necessary in order to do no harm and to create and maintain an effective therapeutic alliance (Shipman & Martin, 2019). For example, I (SC) routinely remind myself I cannot assume the sexual orientation or gender of my clients based on their presentation in therapy. For example, when a cisgender, bisexual client (as indicated on their initial paperwork) discusses a romantic relationship, I ask for their partner's pronouns rather than assume their gender. The process of being respectfully curious directly impacts our ability to be discerning and impartial at the same time. As therapists and supervisors, regardless of our own sexual orientation or gender identities, we must be responsible for our values. In part this means recognizing our beliefs and assumptions and not placing them on the people we encounter (American Association for Marriage and Family Therapy [AAMFT], 2015). Because sexual and gender identities are marginalized in society, all therapists must be mindful of the implications

of self-disclosure. When a client either does or does not gain context for a therapist/supervisor's positionality, the responsibilities and implications are different for LGBTQ+ therapists/supervisors than for heterosexual/cisgender therapists. This chapter focuses on the specific context and implications surrounding when a therapist self-discloses an LGBTQ+ identity in a therapy session.

Types of Self-Disclosure

When thinking about the purpose and impact of self-disclosure, it is important to consider the circumstances in which self-disclosure might occur. Zur et al. (2009) outline three types of self-disclosure: deliberate self-disclosure, unavoidable self-disclosure, and accidental self-disclosure. We discuss how sexual and gender identity disclosure can be understood through each type.

Deliberate

Deliberate disclosure is probably the one that most therapists and supervisors recognize and identify with (Zur et al., 2009). This type of disclosure is intentional and can be expressed verbally and nonverbally. This can include, but is not limited to, sharing information verbally about one's sexual orientation, gender identity, marital status, age, spiritual orientation, and nonverbally such as the display of personal family photos in one's therapy office or jewelry that represents a marital status or religious affiliation. Positionality matters as well—for instance, a cisgender male therapist referencing his wife is perceived differently than a cisgender male therapist referencing his husband. We discuss these considerations in more detail in the section on ethical decision-making.

Another form of deliberate self-disclosure is to advertise oneself as an LGBTQ+ affirmative therapist. It is also a way for therapists to be responsive to society's oppression of sexual and gender minorities by publicly acknowledging one's own expertise and desire to serve the community. It is increasingly common for therapist locator services, such as AAMFT's Therapist Locator or Psychology Today's Therapist Finder, to include LGBTQ+ as an option for a specialty or a particular community with which one works. While these options do not specifically identify the sexual and gender identity of the therapist, the therapist can choose to self-identify in the biography or "about me" section of these advertisement services or through their company's webpages. In addition to these mainstream therapist locator services, LGBTQ+ affirmative therapists form communities through various social media platforms, such as Facebook. For instance, I (ELG) am a member of a Facebook group of over 3,500 self-identified affirmative therapists across the United States. In addition to sharing resources and providing support, it is common for members to ask for referrals for specific clients, often indicating that the client would like to work with a therapist that holds particular identities (e.g., a gay male therapist of color). Therapist-client matching on various aspects of social location, such as gender and race, has been researched in the counseling literature (Cabral & Smith, 2011; Ertl et al., 2019; Wintersteen et al., 2005); one main finding is that clients tend to prefer a therapist that shares their racial identity (Cabral & Smith, 2011). While there have been fewer studies on sexual orientation matching (see Jones et al., 2003; Liddle, 1996), the literature that does exist suggests that some LGBTQ+ clients prefer to have a therapist who matches their sexual orientation or a therapist of a specific gender (O'Shaughnessy & Speir, 2018).

A therapist and supervisor taking the responsibility to identify themselves publicly as an LGBTQ+ identified therapist gives LGBTQ+ clients some power over their mental health care, which may be important given that diverse sexual orientations and gender identities have been historically pathologized within the mental health system. However, this is a decision that LGBTQ+ therapists must consider carefully given that public disclosure of their LGBTQ+ identity is not without consequences. Therapists must be ready to be publicly "out" in their

communities. Further, while having an LGBTQ+ identified therapist may be seen as a positive for many clients, it could also be seen as a negative for others. Clients with negative attitudes toward diverse sexual and gender identities may not want to work with an LGBTQ+ identified therapist. Importantly, identifying as an LGBTQ+ therapist publicly does not imply that self-disclosure to clients within the therapeutic context is irrelevant or unnecessary. All members of client systems may not be aware of the therapist's identities. For instance, one partner in a couple may have set up the services without considering how their partner may feel about working with a queer therapist. Even though the therapist identifies publicly as queer on their website, one member of the couple can still arrive unaware; thus, self-disclosure by the therapist may become relevant during treatment.

Unavoidable

Unavoidable self-disclosure differs from deliberate and accidental self-disclosure because these are parts of the therapist or supervisor's identity that cannot be easily hidden, such as race, a visible disability, body language, or attire. Certain situations or populations we work with may require the therapist or supervisor to become comfortable with transparency, especially if the disclosure cannot be avoided (Zur et al., 2009). For example, an LGBTQ+ therapist or supervisor might see their clients or supervisees at local or national LGBTQ+ pride events. Furthermore, an LGBTQ+ therapist in a same-sex relationship and living in a small town will need to navigate disclosure strategies within and outside of therapy if they are a visible member of the LGBTQ+ community (e.g., discerning whether to show affection to one's partner in public).

Accidental

Accidental self-disclosure is described as the unintentional sharing of details that reveal some personal aspect of the therapist or supervisor. For instance, a woman therapist may unintentionally refer to their wife in front of a client, thus sharing that they are partnered with a woman. Other forms of accidental self-disclosure could include a client seeing their LGBTQ+ therapist with a same-sex partner in public (as discussed above). Furthermore, an LGBTQ+ therapist's partner coming to one's office unexpectedly could have implications for accidental disclosure.

Some therapists, supervisors, clients, or supervisees, regardless of one's sexual orientation or gender identity, might question the need to disclose this information. As previously mentioned, disclosing these identities might be unavoidable or unintentional in certain contexts (Zur et al., 2009). This is especially true for therapists who work in small communities where discretion is limited or not an option. Additionally, clients and supervisees might seek out therapists or supervisors who share one or more of their identities (Gonyea et al., 2014). This sense of similarity can be especially comforting and have a meaningful impact on treatment (Hearn & West-Olatunji, 2015). The delicate balance of self-disclosure should ultimately be regarded on a case-by-case basis (Guthrie, 2006). Next, we expand on various ethical issues to consider given the context of one's role as a therapist, supervisor, and/or supervisee.

Ethical Decision-Making Around Self-Disclosure in Therapy

The AAMFT code of ethics does not provide clear guidelines regarding therapist self-disclosure (AAMFT, 2015). As a result, consultation and supervision become vital resources to making decisions on a case-by-case basis. Pettyjohn et al. (2019) highlight therapist self-disclosure as being clinically relevant and time sensitive. Some therapy models advocate for self-disclosure in order to decrease power differentials (Roberts, 2005), based on the idea that the therapist holds more power in the relationship. However, it may be argued that there are instances in which the therapist holds multiple marginalized identities while working with a client who holds multiple privileged identities, thereby shifting the power dynamic in the relationship

(Pettyjohn et al., 2019). For instance, a queer, nonbinary, feminine presenting therapist of color who is working with a white cisgender man may be acutely aware of the differences in their relative power in the world due to the pervasiveness of racism and sexism. However, the therapist may not be readily aware that their client is gay or from a Middle Eastern heritage, or is Islamic, due to the invisibility of these marginalized identities. The therapist may run the risk of minimizing a client's lived experiences if a safe space is not created for this exploration. Depending on the client and therapist's intersections of identity, the risks and protections experienced may vary. In some cases, self-disclosure and acknowledgment of the therapist's social position can be a powerful tool to help a client to self-disclose and explore their own areas of marginalization. For example, a therapist's self-disclosure of being a person of color and queer may help a client to feel less alone and safe enough to discuss their own intersections of identity. However, a therapist's self-disclosure of a marginalized social identity may have varied implications. Safety is one key aspect to consider in the decision-making process (Shipman & Martin, 2019). Given the current political and social climate in the United States (Benson, 2013), it would be a mistake to ignore the risks involved in a therapist's self-disclosure of LGBTQ+ identity(ies). Disclosure may understandably create increased anxiety for the therapist as well as the client.

The context, clinical relevance, and timing have significant implications for disclosure (Roberts, 2005). For instance, Ashton, an African American, Christian, queer identified therapist, began home-based family therapy with a family consisting of two parents in their early 40s and two teenagers aged 14 and 16. Over the course of three sessions, the parents disclosed their conservative Christian belief system while describing a heated family feud. The parents revealed a strong dislike for their gay identified nephew. They explained that they would not allow their kids to have any contact with the nephew because he "must be some kind of pervert." Ashton shared in supervision that he came out as queer less than two years ago and experienced several instances of being rejected by his family of origin as well as his church. Ashton wondered if he should disclose his sexual orientation to his client.

The social positions of both the therapist and the client inform the therapeutic relationship. Some of Ashton's identities are marginalized (African American, queer) and some are privileged (cisgender male, Christian). Ashton and the parents share a Christian identity, although it is unknown if the teenagers share the same belief system or opinions as their parents or with each other. Ashton's clients appear to occupy some privileged positions (white, Christian) while their socioeconomic status is marginalized (low SES). In this example, Ashton's evaluation of risk for self-disclosure also includes the setting in which he practices. Home visits may introduce additional safety concerns. Because the client is not bound by confidentiality as therapists are, it is possible that his disclosure could be revealed to others. If this occurred, would there be a safety concern in the neighborhood or the home where Ashton provides therapy? How would the therapeutic process be impacted if the family later found out Ashton was queer identified? Would the reactions differ among family members? For instance, it is possible that some family members may find Ashton's disclosure useful and others may see it as oversharing or a boundary violation (Roberts, 2005). Furthermore, the intersection of culture may be significant in understanding a family's rules around boundaries. The timing of Ashton's disclosure may influence the family's process around examining homophobic beliefs that may or may not be shared between family members regarding their gay identified family member.

One question aside from that of self-disclosure: is Ashton differentiated enough from his own family challenges in order to disclose information in a helpful way? Because Ashton reported to the supervisor that he came out less than two years ago and had multiple experiences of rejection, the supervisor must support Ashton in determining if he is differentiated enough from his own family challenges in order to work with the family. If not, the supervisor can intervene and transfer the case to another therapist. If Ashton determined a readiness to move ahead with the

case, the supervisor would help Ashton make an informed decision regarding self-disclosure through the process of weighing risks and benefits.

In this case, it would be beneficial for the supervisor to reassure Ashton that he is the only one that can decide if he wants to self-disclose and that he also has a right to his own privacy. If Ashton determined the risk to his sense of safety was too high or that self-disclosure may lead to an unhelpful focus in the therapy process, Ashton may choose not to self-disclose at this time. The supervisor can then prepare Ashton for possible future scenarios through role playing. One such scenario may be that Ashton is confronted by the family about his queer identity. The supervisor can instruct Ashton to move toward a curious position to allow for the family to be reflective of their experience. "What is it like for you to know about my sexual orientation? How might this affect how we work together? Now that you know this about me, how does this impact how you see your gay identified family member?" If the family appears upset that this disclosure did not occur earlier, the therapist could be coached to acknowledge those feelings as well.

> I'm sorry you feel that way and I didn't mean to hurt you. I'd like for you to know that I don't often disclose personal information unless I feel that our therapeutic process would benefit from it. What is it like for you to not know everything about me?

Through validation and acknowledgment of family members concerns, thoughts, and feelings, the therapist can then connect the conversation toward relevant patterns in the family.

If Ashton determined that the benefits outweigh the risks of self-disclosure, supervision may be used to discuss when disclosure is most beneficial and for Ashton to determine what he is comfortable sharing with the family. Role play regarding multiple and differing reactions among family members may also be helpful. There may be many right answers about timing, and how to self-disclose. One scenario may be that Ashton decides to self-disclose after a few months when he notices the family continues to struggle to see any other options besides rejecting their family member. Ashton discloses that his family had a hard time at first when they learned that he was queer identified and over time they were able to use their religion to move toward being more accepting of him. In this example, Ashton helps the family consider that there may be room in their religious belief system to have a relationship with their family member.

Self-disclosure in this scenario has the possibility of helping the family get unstuck and deepening the therapeutic relationship. Simultaneously, it is possible that the parents decide they will not work with Ashton anymore. In this case, the supervisor would help Ashton deal with any reactions to the family terminating therapy with him. While there may be numerous possibilities in how Ashton and the family decide whether or not to work together, the underlying supervisory process is one in which the supervisor creates a space for exploration of emotions and options, isomorphic to what the therapist might do with the client.

The example above highlights the significance of the therapist's social location and the culture in which it is embedded. Careful exploration of risks and benefits with a supervisor would help Ashton make an informed decision regarding disclosure while prioritizing safety. However, what might this same situation be like if Ashton were a transfeminine identified person? Would the risk of self-disclosure differ?

Individuals that exist outside of a two-gender binary system have historically experienced more victimization (Stotzer, 2009). In general, a person assigned male at birth and a person assigned female at birth often are not afforded the same gender expression flexibility. For instance, a person perceived as an African American boy or a man who wears feminine clothing in a public space may be met with extreme violence. If a person occupies multiple areas of marginalization at the same time, it may also increase risk in disclosure. There is clear evidence that transfeminine individuals, particularly transfeminine people of color, experience violence at a disproportionate rate than white transfeminine people (Stotzer, 2009; U.S. Transgender Survey, 2015).

Let's look at another instance where intersection of social locations is salient. Frankie is a therapist who works in a community center where therapy services are provided to a wide range of clients. Frankie was assigned male at birth and uses they/them/their gender pronouns. Frankie is Latinx and identifies as nonbinary, though most people perceive them as a white cisgender male. Frankie reported discomfort to their supervisor regarding being repeatedly misgendered (i.e., to address someone, specifically a transgender or gender expansive person, using pronouns that does not reflect their identity) by clients during sessions. Frankie expressed extreme caution because "the last time I disclosed an aspect of identity, such as my ethnicity to my white neighbors, I was told to go back to where I came from."

Sometimes disclosure of a nonbinary or transgender identity is not a choice (Shipman & Martin, 2019). If an individual began a medical gender transition and/or a social gender transition during the ongoing therapy with clients, this may be a visible process. Other times, an individual's transgender or gender expansive identity may be invisible. Frankie's self-disclosure may present different risks based on the intersection of their client's social location. In addition to considering safety concerns, self-disclosure of a nonbinary gender identity to cisgender clients may require spending time exploring the impact on the therapeutic relationship. Gender roles and rules often govern how people interact. How will the relationship adjust to this new expansive understanding of gender? How might one's religious beliefs, transphobia, or homophobia impact the therapeutic relationship?

It may also be more difficult for Frankie to self-disclose their marginalized position when the client is privileged in that identity (Pettyjohn et al., 2019). For example, cisgender parents of questioning youth may seek therapy in hopes that the therapist will help their child accept and live life as a cisgender, heterosexual person (Shipman & Martin, 2019). The timing and impact of the therapist's self-disclosure may carry various risks. The therapist may be in an important position of helping the parents become more attuned to the needs of their own nonbinary or gender expansive child. Therefore, awareness of the therapeutic relationship across the family system is vital. It is possible that Frankie could gain credibility upon disclosure with the parent of the questioning youth. However, parents may also worry that the therapist could encourage an LGBTQ+ identity and may seek services elsewhere. Many young people feel alone in their LGBTQ+ identities, and it may be tempting for the therapist to self-disclose shared identities with the youth. However, if the parents are also not informed and are not yet supportive, there may be additional risks. The young person's ability to access transition-related support, for example, may be jeopardized (Shipman & Martin, 2019). Furthermore, secret keeping between the therapist and young client may be an unfair request. Inadvertently, the young person may be placed in a position of competing loyalties between the therapist and their parents.

Depending on the therapist's social positioning regarding gender and sexual orientation, self-disclosure may have various impacts with LGBTQ+ clients. There may be instances where it is simultaneously helpful and risky. Some clients may enter therapy feeling as if they are the only one in the world with their particular experience. For instance, a client identifying as a gay, Muslim man may feel less isolated after their therapist self-discloses a shared gay identity. However, it is possible that the client may also refrain from sharing experiences of shame around their identity because their therapist "seems so proudly gay." Minimizing risk may mean the acknowledgment of the client and therapist's intersections. If, for example, the therapist acknowledged the intersection of the client's Muslim identity, it may allow space for how culture and religion may impact the experience of shame around their sexuality as well.

Pettyjohn et al. (2019) reported that in recent years, additional dimensions of power and oppression such as gender identity, citizenship status, and Muslim or non-Muslim have become more relevant in the United States. In the case of Frankie, they occupy more than one marginalized identity (Latinx and nonbinary). For instance, Frankie's life experience of living outside of

the gender binary paired with daily fears surrounding threats of detention or deportation are all invisible. Since Frankie is often perceived as a white, cisgender male by their clients, it may be a potential barrier to a strong therapeutic relationship with LGBTQ+ clients without self-disclosure. Pettyjohn et al. (2019) discussed how the therapist and client's identities which differ from one another may negatively influence the client's level of comfort as well as the therapeutic process. We would argue that this may be especially true for those who occupy marginalized identities such as LGBTQ+.

It may have felt like a risk for Frankie to share in supervision about their discomfort of being misgendered by clients. In this situation, it is important that the supervisor listen and respond with acknowledgment and validation. First and foremost, Frankie may not realize they have agency around asserting their pronouns. It is recommended that the supervisor overtly tell Frankie they will be supported as they navigate pronoun usage in sessions. The supervisor can begin by encouraging Frankie to explore what it might be like to assert their gender pronouns. Allotting time in supervision may be useful to evaluate risks and benefits, play out various scenarios, and process any of Frankie's fears and worries. For example, clients may become curious or uncomfortable about Frankie's gender identity. In this case, Frankie will need to be clear about what to self-disclose. As Frankie practices conversations in supervision and with clients, they will finesse the clinical skills of redirecting the client to be reflective of their own experience. At times, this may lead to therapeutic discussions around the role of gender in their clients' lives. Another scenario may be that some clients may decide they do not want to work with Frankie after Frankie shares their gender pronouns. In this case, it is important that the supervisor supports and affirms Frankie through the process of termination.

A considerable amount of self-work may be beneficial while making decisions around self-disclosure. In the above example with Ashton, self-work around family of origin issues and examining how religion intersected with his sexual orientation were important in deciding to disclose. Sometimes this work may need to happen in therapy outside of supervision as well. Similarly, with Frankie, their own experience of gender in relationships needed to be explored. Self-awareness of internalized transphobia and homophobia are important first steps. For instance, the therapist may risk upholding rigid traditional binary ideas of what it means to be a lesbian or a woman in the world or that there is only one path to gender transition (Shipman & Martin, 2019). Furthermore, when therapists fail to acknowledge the intersection of identities, they may risk the reinforcement of power and oppression. Responsibility for therapist's self-disclosure may include making room for diverse identities and expressions of their clients as well (Benson, 2013; Shipman & Martin, 2019). If this does not occur, the client may begin to compare themselves to the therapist in unhelpful ways. The therapist and client may begin to intertwine their stories sacrificing the client's ability to focus on their unique experience and position (Roberts, 2005). Expanding the paradigm to an intersectional framework allows for multiple LGBTQ+ narratives (Addison & Coolhart, 2015). It is also important to consider that therapist self-disclosure may occur more than once. The intersection of gender and sexuality may evolve over one's lifetime, while other identity markers may not.

Relationships in good standing are important in whether self-disclosure interventions are successful (Clevinger et al., 2019). A solid base of trust that a therapist or supervisor has with their clients or supervisees is essential. This environment is also conducive to strong alliances with clients and whether or not disclosure is effective (Knox et al., 2008; Pepping et al., 2018). Clients and supervisees who identify with one or more marginalized identities may find comfort in their LGBTQ+ therapist disclosing a similar identity. I (SC) have found this particularly effective in my work with LGBTQ+ clients of color because I always present as a Black woman, but my sexual identity as a bisexual is less visible. In this case, clients usually respond with relief that not only were they able to find a Black therapist in their area, but *also* were able to find a

Black LGBTQ+ therapist. Furthermore, a discussion in therapy or supervision can address the interpersonal process of this exchange (Bruce et al., 2010).

Self-Disclosure as a Supervisee

Supervision is an environment in which novice therapists are meant to hone their clinical approaches as well as examine their assumptions guiding those approaches. Bordin (1983) believed the components of a supervisory working alliance, which consist of agreement between supervisor and supervisee about the goals and tasks of supervision, and an emotional bond between them. In order to engage in this critical self-of-the-therapist work in supervision settings, supervisees must engage in some form of self-disclosure, which requires the above components to be present prior to self-of-therapist work.

Making the decision to disclose a sexual or gender minority status as a supervisee is often a challenging one for many LGBTQ+ individuals. Disclosing any information in supervision requires vulnerability, and disclosing sensitive topics requires even more vulnerability due to increased risk of harm. The existing literature on LGBTQ+ disclosure in supervision specifically, however, is limited. Some authors have discussed the need to attend to issues of diversity and social justice with sexual minorities (Satterly & Dyson, 2008), while Shipman and Martin (2019) detail the special considerations regarding transgender identified therapists in both supervision and therapy. The literature highlights the need for cultural humility to avoid further marginalization of the supervisee. For instance, a cisgender and/or heterosexual supervisor may not be aware of issues surrounding marginalization, transphobia, and homophobia. These areas may impact a therapist's ability to navigate decisions regarding self-disclosure. Supervisors must initiate and expand conversations regarding gender, sexual orientation, race, class, etc. (Garcia et al., 2009; Hardy & Laszloffy, 1995; Shipman & Martin, 2019). If supervisors work toward an environment of safety, supervisees can develop their clinical skills without fear of a supervisor's lack of awareness affecting their evaluations (Satterly & Dyson, 2008). Clearly, supervisors need to be aware of these specific considerations in working with their LGBTQ+ supervisees. Supervisees may decide to self-disclose when one or more of their intersecting identities is impacting their clinical work. Supervisees likely feel anxious, hesitant, or cautious about disclosing to supervisors with which they are unfamiliar (Burkard et al., 2009; Gray et al., 2001). Researchers have found that supervisees choose not to disclose to supervisors when a poor relationship exists previous to the potential disclosure opportunity (Hess et al., 2008; Ladany et al., 1996).

Often, LGBTQ+ supervisees seek out indications of an affirming supervisor prior to disclosing by discussing sexual orientation and gender issues among their clients (Burkard et al., 2009; O'Brien & Rigazio-DiGilio, 2016). Presenting the issues in this way allows for supervisees to assess the trustworthiness of supervisors by gauging how much they value discussing the topics. Affirming and non-affirming experiences in supervision clearly have a significant impact on an LGBTQ+ supervisee. Affirmative supervision is generally one without heteronormative and pathological assumption related to sexual minorities (O'Brien & Rigazio-DiGilio, 2016). Affirming supervision also included the presence of collaborative and safe dialogue among the supervisor and supervisee group about biases, assumptions, and knowledge related to sexual minority topics. Affirming supervisors were generally characterized as addressing heteronormative assumptions, biases, and discrimination. Participants described non-affirmative supervision as including heteronormative and pathological assumptions about sexual minorities, and lacking a collaborative and safe dialogue around biases and assumptions (O'Brien & Rigazio-DiGilio, 2016).

Supervisees who experience non-affirming events often reported poor relationships with supervisors prior to the disclosure (Burkard et al., 2009). Supervisees may feel the need to protect themselves during supervision or may even disclose less about their clients and withdraw

from the process of supervision altogether (Gray et al., 2001; Nelson & Friedlander, 2001). Disengaging from supervision can have serious consequences, since this is the medium through which supervisees learn how to be ethical and effective therapists (Watkins & Milne, 2014). Supervisees often want topics related to sexual minorities to be addressed via self-of-therapist work (Burkard et al., 2009). Some researchers suggest that a lack of this type of self-of-therapist work could suggest a bias, discomfort, or lack of knowledge related to the importance of a minority perspective (Croteau et al., 2005; O'Brien & Rigazio-DiGilio, 2016). This also signals to supervisees that addressing prominent self-of-therapist issues is unnecessary, which could lead to unethical practices.

Supervisors should take an active approach to understanding LGBTQ+ issues and discussing them in supervision. Awareness must be present among supervisors in order to address non-affirming events that may happen. Regular feedback loops should be encouraged, but it is crucial that supervisors create a safe space in which such feedback can be given. Supervisors should engage in regular consultation with colleagues and seek relational repair with supervisees if they cause any emotional damage. By owning their errors, supervisors can model accountability for developing therapists through an isomorphic process. Participants in the study by Burkard and colleagues (2009) wished their supervisors had recognized their errors and addressed non-affirming events with them in an attempt to validate the emotional impact on them. Supervisor training should critically examine biases and ways to address issues that arise with supervisees. A good suggestion for training is a review of Halpert and colleagues (2007) integrative affirmative supervision model.

Self-Disclosure as a Supervisor

An LGBTQ+ supervisor is in a unique position to effect change regarding heteronormative, mononormative (e.g., privileging a sexual or romantic attraction toward one person; Rust, 2000), and cisnormative assumptions of novice therapists. Considering supervisors are in a position of power, they must use it wisely and effectively. There is a delicate balance of addressing minority status and not over-focusing on it. One cannot ignore it, but also should not continue to discuss it if it has been addressed adequately. Over-focusing on the minority status could run the risk of creating a problem where one does not exist. Mizock and Lundquist (2016) refer to this over focus as *inflation*, or the exaggerated focus on any one minority identity that excludes exploration of other aspects of the therapeutic process. Within the context of supervision, identity inflation can arise in self-of-therapist discussions as well as case conceptualizations.

It is the responsibility of the supervisor to facilitate discussions that balance exploration into all aspects of the supervisee's difficulties with the client. For instance, a supervisor could falsely assume that a heterosexual supervisee is resistant to feedback because they are experiencing countertransference from a sexual minority client solely due to the differences in their sexual orientation. Inflating sexual orientation during the supervision discussion would take supervision off track and potentially objectify the client's identity. Instead, the supervisor should facilitate self-of-therapist exploration on various aspects of the therapeutic process to provide an effective supervision experience. Supervisors could then utilize transparency to explain their rationale for engaging in these self-of-therapist discussions, reflecting the process back to the clients' experience in therapy. Transparency can foster an effective supervisory alliance as well as provide a safe environment for supervisees to be open and honest (Knight, 2012). Additionally, transparency is likely to minimize the risk or impact of tension caused by differences in how supervisors and supervisees define what is inflation.

Ignoring minority status, however, sends the message that it should not be talked about or does not matter, which then translates to avoidance in the therapy room through an isomorphic process (Knight, 2012). Avoiding the topic of identity creates an unsafe space to discuss the

issues when they impact the therapist's ability to provide effective therapeutic care. Supervisor self-disclosure can be a way to begin critical conversations, as it can personalize the content delivery. This process, however, requires considerable thought into the purpose of such disclosure (Nedela et al., 2018).

Farber (2006) theorized that supervisors disclose in order to strengthen the supervisory relationship, share what they have learned from their own professional experiences, model therapy skills, and provide feedback to supervisees. Research generally supports this theory. Supervisors often use self-disclosure in order to enhance the development of supervisees and to normalize their experiences (Knox et al., 2008). For instance, a supervisor could disclose mistakes they have made and the lessons they have learned to improve those mistakes. Disclosure usually occurs when supervisees are struggling and supervisors focus on their own reactions to their supervisee's clients, perhaps sharing about their own experiences with previous clients with the intent to teach and normalize. Supervisor self-disclosure is often viewed positively by supervisees, when it is focused on normalizing experiences for trainees (Clevinger et al., 2019). A strong relationship prior to disclosure will assist in a positive perception of the disclosure, and aid in professional development and clinical competency. In our experience, a strong supervisory relationship is developed through clear expectations, highlighting strengths, and presenting opportunities for growth in ways that encourage rather than discourage development.

Self-disclosure of sexual or gender minority identity among LGBTQ+ supervisors, then, ideally occurs in the context of normalizing supervisee experiences or aiding in their professional development. An example of normalizing supervisee experiences is when they encounter discrimination in an internship setting. A supervisor could share their experiences of discrimination related to their sexual or gender minority identity and how they were able to deal with the situation. An example of self-disclosure aiding supervisees in professional development is sharing an experience of countertransference with a previous client who was homophobic. Self-disclosure in this example could highlight the impact that clients can have on therapists, in addition to an opportunity to discuss biases and assumptions on a larger spectrum for supervisees. Disclosing in this instance, however, may also make supervisees feel restricted in their full exploration of biases if they feel they may offend the supervisor. We recommend that the supervisor explicitly acknowledge this risk and encourage an open dialogue around bias. Supervisors, again, should consider the pros and cons of disclosure.

As an LGBTQ+ supervisor who may be supervising an LGBTQ+ supervisee, it is important to avoid making assumptions about similarities based on the shared minority status, and likewise important to remember whose hour is it (Perlstein, 2009). Disclosing their experiences as an LGBTQ+ therapist may help normalize their supervisees experiences, and possibly help the supervisee feel safe in the supervisory relationship. However, supervisors should avoid assumptions that LGBTQ+ supervisees are free from bias. Supervisees must continue to assist in professional development discussions around biases and assumptions as they would any other supervisee.

Supervisors must also be careful to protect LGBTQ+ supervisees within a group setting if they do not wish to disclose their identities. Trainees need the space to not reveal anything if they do not want to (Perlstein, 2009). Instead, they can discuss that there is a personal connection or countertransference present with a client and the process of recognizing this can be discussed in supervision broadly. The supervisor can encourage supervisees to engage in therapy to further explore the issues that are causing countertransference as needed.

Obviously, there are times when self-disclosure as a supervisor poses significant risks. Similar to the risks involved with supervisee self-disclosure in supervision, if there is not an accepting environment, or there is a lack of strong supervisory relationship, self-disclosure can cause negative consequences. For example, supervisees with strong conservative beliefs may not feel

comfortable with an LGBTQ+ supervisor and disengage from the supervision process for fear of retaliation for their beliefs. Such supervisees also need to be provided with a safe space to examine their beliefs. Avoiding immediate self-disclosure as a supervisor may be important in these instances. Supervisors may benefit from engaging in discussions around biases and assumptions prior to self-disclosure in order to develop a strong supervisory relationship. For example, it may be necessary to talk directly about the differences which exist between a supervisor and supervisee (e.g., conservative/liberal or LGBTQ/heterosexual) as a way to create safer dialogue. A supervisor could say, "My hope as your supervisor is to create healthy discussions which are respectful and challenging so that our differences are useful to the supervision." Again, self-disclosure is helpful in situations that help normalize supervisee experiences or aid in their professional development.

As this chapter is being finalized, the Supreme Court issued a decision that interprets the meaning of the Title VII statute of the Civil Rights Act of 1964 to prohibit workplace discrimination based on sexual orientation or gender identity in the workplace (Liptak, 2020). Before this, employers could choose whether their settings had clear non-discrimination policies that included sexual and gender minorities. Disclosure could be risky in situations where there are no non-discrimination protections. Supervisors in these settings ran the risk of being terminated if they disclose their identities.

Conclusion

People who identify as LGBTQ+ are often discriminated against at multiple levels within society due to the heteronormative and cisnormative systems in place that allow for certain groups to be privileged while other groups are oppressed. This becomes more complex when we consider the intersecting identities of race and culture. Therapists who are considering self-disclosing their LGBTQ+ identity in therapy or in supervision must consider the ethical implications of disclosing and how this information will impact their clinical work and therapeutic or supervisory alliance. In this chapter, we offered multiple best practices for self-disclosure in therapy and supervision. We outlined in the chapter potential blind spots to consider prior to a self-disclosing event in therapy or in supervision, in order to prevent doing harm. Self-disclosure can benefit the field of therapy by centering LGBTQ+ identity, build awareness on behalf of therapists, supervisors, and supervisees, and play a part in dismantling the sexual and gender norms in our society which inevitably impacts every aspect of our clinical work with individuals, couples, and families.

References

Addison, S. M., & Coolhart, D. (2015). Expanding the therapy paradigm with queer couples: A relational intersectional lens. *Family Process, 54*(3), 435–453. https://doi.org/10.1111/famp.12171

American Association for Marriage and Family Therapy. (2015). *Code of ethics.* https://www.aamft.org/Legal_Ethics/Code_of_Ethics.aspx

Barnett, J. E. (2011). Psychotherapist self-disclosure: Ethical and clinical considerations. *Psychotherapy, 48*(4), 315–321. https://doi.org/10.1037/a0026056

Bauer, G. R., Hammond, R., Travers, R., Kaay, M., Hohenadel, K. M., & Boyce, M. (2009). "I don't think this is theoretical; this is our lives": How erasure impacts health care for transgender people. *Journal of the Association of Nurses in Aids Care, 20*(5), 348–361. https://doi.org/10.1016/j.jana.2009.07.004

Benson, K. E. (2013). Seeking support: Transgender client experiences with mental health services. *Journal of Feminist Family Therapy, 25*(1), 17–40. https://doi.org/10.1080/08952833.2013.755081

Bordin, E. S. (1983). A working alliance-based model of supervision. *The Counseling Psychologist, 11*(1), 35–41. https://doi.org/10.1177/0011000083111007

Bruce, N. G., Manber, R., Shapiro, S. L., & Constantino, M. J. (2010). Psychotherapist mindfulness and the psychotherapy process. *Psychotherapy: Theory, Research, Practice, Training, 47*(1), 83–97. https://doi.org/10.1037/a0018842

Burkard, A. W., Knox, S., Hess, S. A., & Schultz, J. (2009). Lesbian, gay, and bisexual supervisees' experiences of LGB-affirmative and non-affirmative supervision. *Journal of Counseling Psychology, 56*(1), 176–188. https://doi.org/10.1037/0022-0167.56.1.176

Cabral, R. R., & Smith, T. B. (2011). Racial/ethnic matching of clients and therapists in mental health services: A meta-analytic review of preferences, perceptions, and outcomes. *Journal of Counseling Psychology, 58*(4), 537–554. https://doi.org/10.1037/a0025266

Chodzen, G., Hidalgo, M. A., Chen, D., & Garofalo, R. (2019). Minority stress factors associated with depression and anxiety among transgender and gender-nonconforming youth. *Journal of Adolescent Health, 64*(4), 467–471. https://doi.org/10.1016/j.jadohealth.2018.07.006

Clevinger, K., Albert, E., & Raiche, E. (2019). Supervisor self-disclosure: Supervisees' perceptions of positive supervision experiences. *Training and Education in Professional Psychology, 13*(3), 222–226. https://doi.org/10.1037/tep0000236

Croteau, J. M., Lark, J. S., Lidderdale, M. A., & Chung, Y. B. (2005). *Deconstructing heterosexism in the counseling professions: Multicultural narrative voices.* Sage.

Diaz, G. Cabrera, G., Moore, C., & Yakas, L. (2019). Woke to weary. *Public Culture, 31*(2), 373–391. https://doi.org/10.1215/08992363-7286873

Ertl, M. M., Mann-Saumier, M., Martin, R. A., Graves, D. F., & Altarriba, J. (2019). The impossibility of client-therapist "match": Implications and future directions for multicultural competency. *Journal of Mental Health Counseling, 41*(4), 312–326. https://doi.org/10.17744/mehc.41.4.03

Farber, B. A. (2006). *Self-disclosure in psychotherapy: Patient, therapist, and supervisory perspectives*. Guilford.

Follins, L. D., Walker, J. J., & Lewis, M. K. (2014). Resilience in black lesbian, gay, bisexual and transgender individuals: A critical review of the literature. *Journal of Gay & Lesbian Mental Health, 18*(2), 190–212. https://doi.org/10.1080/19359705.2013.828343

Garcia, M., Kosutic, I., McDowell, T., & Anderson, S. A. (2009). Raising critical consciousness in family therapy supervision. *Journal of Feminist Family Therapy, 21*(1), 18–38. https://doi.org/10.1080/08952830802683673

Gonyea, J. L. J., Wright, D. W., & Earl-Kulkosky, T. (2014). Navigating dual relationships in rural communities. *Journal of Marital and Family Therapy, 40*(1), 125–136. https://doi.org/10.1111/j.1752-0606.2012.00335.x

Graham, L. F. (2014). Navigating community institutions: Black transgender women's experiences in schools, the criminal justice system, and churches. *Sexuality Research and Social Policy, 11*(4), 274–287. https://doi.org/10.1007/s13178-014-0144-y

Gray, L. A., Ladany, N., Walker, J. A., & Ancis, J. R. (2001). Psychotherapy trainees' experience of counterproductive events in supervision. *Journal of Counseling Psychology, 48*(4), 371–383. https://doi.org/10.1037/0022-0167.48.4.371

Guthrie, C. (2006). Disclosing the therapist's sexual orientation: the meaning of disclosure in working with gay, lesbian, and bisexual patients. *Journal of Gay & Lesbian Psychotherapy, 10*(1), 63–77. https://doi.org/10.1300/J236v10n01_07

Halpert, S. C., Reinhardt, B., & Toohey, M. J. (2007). Affirmative clinical supervision. In K. J. Bieschke, R. M. Perez, & K. A. DeBord (Eds.), *Handbook of counseling and psychotherapy with lesbian, gay, and bisexual clients* (2nd ed., pp. 341–358). American Psychological Association. https://doi.org/10.1037/11482-014

Hardy, K. V., & Laszloffy, T. A. (1995). The cultural genogram: Key to training culturally competent family therapists. *Journal of Marital and Family Therapy, 21*(3), 227–237. https://doi.org/10.1111/j.1752-0606.1995.tb00158.x

Hearn, B. G., & West-Olatunji, C. (2015). Deciding to disclose: The LGBTQ counselor's unique challenge. *Ideas and Research You Can Use: VISTAS 2015.* https://www.counseling.org/knowledge-center/vistas/by-year2/vistas-2015/docs/default-source/vistas/article_742acd23f16116603abcacff0000bee5e7

Hess, S. A., Knox, S., Schultz, J. M., Hill, C. E., Sloan, L., Brandt, S., Kelley, F., & Hoffman, M. A. (2008). Predoctoral interns' nondisclosure in supervision. *Psychotherapy Research, 18*(4), 400–411. https://doi.org/10.1080/10503300701697505

Hill, D. B., & Willoughby, B. L. B. (2005). The development and validation of the genderism and transphobia scale. *Sex Roles, 53*(7–8), 531–544. https://doi.org/10.1007/s11199-005-7140-x

Jones, M. A., Botsko, M., & Gorman, B. S. (2003). Predictors of psychotherapeutic benefit of lesbian, gay, and bisexual clients: The effects of sexual orientation matching and other factors. *Psychotherapy: Theory, Research, Practice, Training, 40*(4), 289–301. https://doi.org/10.1037/0033-3204.40.4.289

Kelly, A., & Rodriguez, R. (2007). Do therapists self-disclose more to clients with greater symptomatology? *Psychotherapy: Theory, Research, Practice, Training, 44*(4), 470–475. https://doi.org/10.1037/0033-3204.44.4.470

Knight, C. (2012). Social workers' attitudes towards and engagement in self-disclosure. *Clinical Social Work Journal, 40*(3), 297–306. https://doi.org/10.1007/s10615-012-0408-z

Knight, C. (2014). Students' attitudes towards and engagement in self-disclosure: Implications for supervision. *The Clinical Supervisor, 33*(2), 163–181. https://doi.org/10.1080/07325223.2014.981493

Knox, S., Burkard, A., Edwards, A., Smith, J. J., & Schlosser, L. Z. (2008). Supervisors' reports of the effects of supervisor self-disclosure on supervisees. *Psychotherapy Research, 18*(5), 543–559. https://doi.org/10.1080/10503300801982781

Ladany, N., Hill, C. E., Corbett, M. M., & Nutt, E. A. (1996). Nature, extent, and importance of what psychotherapy trainees do not disclosure to their supervisors. *Journal of Counseling Psychology, 43*(1), 10–24. https://doi.org/10.1037/0022-0167.43.1.10

Liddle, B. J. (1996). Therapist sexual orientation, gender, and counseling practices as they relate to ratings on helpfulness by gay and lesbian clients. *Journal of Counseling Psychology, 43*(4), 394–401. https://doi.org/10.1037/0022-0167.43.4.394

Liptak, A. (2020, June 15). *Civil rights law protects gay and transgender workers, Supreme Court rules.* The New York Times. https://www.nytimes.com/2020/06/15/us/gay-transgender-workers-supreme-court.html

Marchia, J., & Sommer, J. M. (2019). (Re)defining heteronormativity. *Sexualities, 22*(3), 267–295. https://doi.org/10.1177/1363460717741801

Matsuzaka, S., & Koch, D. E. (2018). Trans feminine sexual violence experiences: The intersection of transphobia and misogyny. *Journal of Women and Social Work, 34*(1), 28–47. https://doi.org/10.1177/0886109918790929

McCabe, P. C., Dragowski, E. A., & Rubinson, F. (2013). What is homophobic bias anyway? Defining and recognizing microaggressions and harassment of LGBTQ youth. *Journal of School Violence, 12*(1), 7–25. https://doi.org/10.1080/15388220.2012.731664

Mizock, L., & Lundquist, C. (2016). Missteps in psychotherapy with transgender clients: Promoting gender sensitivity in counseling and psychological practice. *Psychology of Sexual Orientation and Gender Diversity, 3*(2), 148–155. https://doi.org/10.1037/sgd0000177

Nagoshi, J. L., Adams, K. A., Terrell, H. K., Hill, E. D., Brzuzy, S., & Nagoshi, C. T. (2008). Gender differences in correlates of homophobia and transphobia. *Sex Roles, 59*(7–8), 521–531. https://doi.org/10.1007/s11199-008-9458-7

Nedela, M., Murray, M., & Steelman, S. (2018). Using self-disclosure to manage student misconceptions in a human sexuality classroom. *International Journal of Critical Pedagogy*, *9,* 29–52. https://www.semanticscholar.org/paper/Using-Self-Disclosure-to-Manage-Student-in-a-Human-Nedela-Murray/a74c84601ce6545c7659e811fd00a1453af6e78d

Nelson, M. L., & Friedlander, M. L. (2001). A close look at conflictual supervisory relationships: The trainee's perspective. *Journal of Counseling Psychology, 48*(4), 384–395. https://doi.org/10.1037/0022-0167.48.4.384

O'Brien, N., & Rigazio-DiGilio, S. A. (2016). Lesbian, gay, and bisexual supervisees' experiences of LGB-affirmative and non-affirmative supervision in COAMFTE-accredited training programs. *Journal of Feminist Family Therapy, 28*(4), 115–135. https://doi.org/10.1080/08952833.2016.1234263

O'Shaughnessy, T., & Speir, Z. (2018). The state of LGBQ affirmative therapy clinical research: A mixed-methods systematic synthesis. *Psychology of Sexual Orientation and Gender Diversity, 5*(1), 82–98. https://doi.org/10.1037/sgd0000259

Pepping, C. A., Lyons, A., & Morris, E. M. J. (2018). Affirmative LGBT psychotherapy: Outcomes of a therapist training protocol. *American Psychological Association, 55*(1), 52–62. https://doi.org/10.1037/pst0000149

Perlstein, M. (2009). Virgins and veterans: Culturally sensitive supervision in the LGBT community. *Women & Therapy, 33*(1–2), 85–100. https://doi.org/10.1080/02703140903404887

Pettyjohn, M. E., Tseng, C., Blow, A. J. (2020). Therapeutic utility of discussing therapist/client intersectionality in treatment: When and how? *Family Process, 59*(2), 313–327. https://doi.org/10.1111/famp.12471

Pisani, A. (2005). Talk to me: Supervisee disclosure in supervision. *Smith College Studies in Social Work, 75*(1), 29–47. https://doi.org/10.1300/J497v75n01_03

Pyne, J. (2011). Unsuitable bodies: Trans people and cisnormativity in shelter services. *Canadian Social Work Review, 28*(1), 129–137. http://www.jstor.org/stable/41658838

Roberts, J. (2005). Transparency and self-disclosure in family therapy: Dangers and possibilities. *Family Process, 44*(1), 45–63. https://doi.org/10.1111/j.1545-5300.2005.00041.x

Rust, P. C. R. (2000). Bisexuality: A contemporary paradox for women. *Journal of Social Issues, 56*(2), 205–221. https://doi.org/10.1111/0022-4537.00161

Satterly, B. A., & Dyson, D. (2008). Sexual minority supervision. *The Clinical Supervisor, 27*(1), 17–38. https://doi.org/10.1080/07325220802221462

Shelton, K., & Delgado-Romero, E. A. (2011). Sexual orientation microaggressions: The experience of lesbian, gay, bisexual, and queer clients in psychotherapy. *Journal of Counseling Psychology, 58*(2), 210–221. https://doi.org/10.1037/a0022251

Shipman, D., & Martin, T. (2019). Clinical and supervisory considerations for transgender therapists: Implications for working with clients. *Journal of Marital and Family Therapy, 45*(1), 92–105. https://doi.org/10.1111/jmft.12300

Simoni, J. (2001). Heterosexual identity and heterosexism: Recognizing privilege to reduce prejudice. *Journal of Homosexuality, 41*(1), 157–172. https://doi.org/10.1300/J082v41n01_06

Solo, C. (2019). Supervising students in emerging adulthood: Modeling use of self in developmentally informed supervision. *Clinical Social Work Journal, 47*(1), 72–78. https://doi.org/10.1007/s10615-018-0674-5

Staples-Bradley, L. K., Duda, B., & Gettens, K. (2019). Student self-disclosure in clinical supervision. *Training and Education in Professional Psychology, 13*(3), 216–221. https://doi.org/10.1037/tep0000242

Stotzer, R. L. (2009). Violence against transgender people: A review of United States data. *Aggression and Behavior, 14*(3), 170–179. https://doi.org/10.1016/j.avb.2009.01.006

Tate, C. (2013). A two-question method for assessing gender categories in the social and medical sciences. *The Journal of Sex Research, 50*(8), 767–776. https://doi.org/10.1080/00224499.2012.690110

U.S. Transgender Survey. (2015). The report of the US transgender survey executive summary. http://www.transequality.org/sites/default/files/docs/usts/Executive%20Summary%20-%20FINAL%201.6.17.pdf

Watkins, Jr., C. E., & Milne, E. (Eds.). (2014). *The Wiley international handbook of clinical supervision.* Wiley. https://doi.org/10.1002/9781118846360

Wintersteen, M. B., Mensinger, J. L., & Diamond, G. S. (2005). Do gender and racial differences between patient and therapist affect therapeutic alliance and treatment retention in adolescents? *Professional Psychology, 36*(4), 400–408. https://doi.org/10.1037/0735-7028.36.4.400

Zur, O., Williams, M. H., Lehavot, K., & Knapp, S. (2009). Psychotherapist self-disclosure and transparency in the internet age. *Professional Psychology Research and Practice, 40*(1), 22–30. https://doi.org/10.1037/a0014745

Taylor & Francis
Taylor & Francis Group
http://taylorandfrancis.com

25
Recovery from Sexual Orientation Change Efforts

Affirming the Intersections of Marginalized Identities among Survivors

JEFFREY S. LUTES[1]

Introduction

Heterosexism is a system of attitudes, bias, and discrimination favoring heterosexual people and relationships, and is the primary force behind past and current efforts to change sexual orientation and gender identity. Sexual orientation change efforts (SOCE) is an umbrella term used to describe an array of methodologies that seek to transform non-heterosexual (LGBTQ) individuals into heterosexual (straight) individuals. SOCE can be rooted in either religious-based or counseling-based methods and are also referred to as reorientation therapy, conversion therapy, reparative therapy, or faith-based "ex-gay" ministries. SOCE are rooted in the widespread social and religious assumption that being straight and cisgender is superior and preferable to being lesbian, gay, bisexual, or transgender. These assumptions justify discrimination and lead lawmakers to vote against equality, employers to fire their LGBTQ workers, parents to disown their children, clergy to teach untrue stereotypes, and to self-hatred among LGBTQ people (Hunt, 2007). Working ethically with survivors of SOCE requires therapists to examine and respond to heteronormative bias and cisgenderism. Since all clients have multiple intersectional identities, it is crucial that affirmative therapists also examine the pervasive influence of other social privileges, such as those based on ethnicity, race, gender, class, religion, and physical abilities. This chapter reviews the history of SOCE and the harmful effects of this practice on LGBTQ people and their families. A collaborative, culture-centered, and strengths-based approach is discussed as an effective and ethical approach for joining clients in conversations that examine heterosexist constructs and are relational, non-hierarchical, and affirming. The author demonstrates how evidence-based therapy, community building, and social justice actions can effectively challenge prejudice, discrimination, and privilege.

Case Study

Sonia and Grace are an interracial couple married four years. Sonia, age 32, is African American and identifies as bisexual. Grace, age 38, identifies as white, lesbian, and transgender. They have been experiencing problems with emotional and sexual intimacy, and sought me out as a therapist because of my history of providing affirmative counseling, as well as advocacy and activism on behalf of the LGBTQ community.

[1] The author acknowledges Marsha McDonough, PhD, for her contributions to the original chapter we co-authored in 2012: Helping Individuals and Families Recover from Sexual Orientation Change Efforts and Heterosexism. In J. Bigner & J. Wetchler (Eds.), Handbook of LGBT-Affirmative Couple and Family Therapy (pp. 443–458). Routledge.

DOI: 10.4324/9780429274626-31

Sonia grew up in a conservative Southern Baptist Church in Georgia. Her early memories include twice-weekly church attendance and her parents' adherence to the child-rearing practices of James Dobson and Focus on the Family. She heard regularly that gay and lesbian people were sinful and mentally unstable, and she internalized that message. After one suicide attempt at age 22, she slowly began coming out to herself and others. Initially, Sonia's parents confronted her with Bible verses and sent her links to Christian counselors and a residential reparative therapy program in a nearby county. She began efforts to change her sexual orientation by seeing a Christian counselor that encouraged her to pray, attend church more often, and dress in traditionally feminine clothing. The counselor frequently read from the Bible during these sessions, while also stating that LGBTQ people are unhappy and that marriage is between "one man and one woman." After about 14 months, Sonia quit seeing this counselor as it became obvious that her relational attractions to other women were growing stronger, rather than diminishing. Shortly thereafter, she met Grace and the situation with her parents deteriorated further. Her father texted her one Sunday afternoon: "Until you repent, neither you or your 'girlfriend' are welcome in this house."

Grace, known as Gary during childhood, was born in East Texas and experienced gender dysphoria from an early age. Her family, which included two older sisters, considered themselves Catholic although they only attended church on holidays and special occasions. In her home, sexual and gender diversities were never discussed. She doesn't remember exactly how, but during her teen years she became aware of the Vatican's official stance on the subject. She remembers hearing rumors about her high school algebra teacher, but she never knew any out LGBTQ people. Her mother once giggled at the antics of "Jack" on Will and Grace before her father abruptly changed the channel. She recalls their "deer in the headlights" look when she came out to them as transgender years later. They didn't talk much about it afterward, opting instead to use the avoidance strategies so often employed by her family to sidestep difficult topics. Eventually, both her parents evolved to full acceptance, although occasional remarks during phone conversations make it clear they still grieve losing a son.

Both Grace and Sonia articulated the trauma experienced by growing up in social, religious, and familial environments that condemned their sexual orientation and gender identity. Sonia stated:

> Pretty much my entire teen years were inundated by messages that what I was feeling inside toward other females was 'sick and sinful.' Everything and everyone around me seemed invested in changing my sexual orientation to what they believed it should be. All that set me up to seek counseling as a young adult to try to change. During those years, I really thought I was going to Hell for my same-gender-loving feelings.

Grace nodded and added,

> I didn't go to counseling like Sonia did, but I was surrounded by very similar religion-based bigotry and misunderstanding. You know, if you stop and think about it, it is no wonder that we struggle with emotional intimacy and communication as a couple. Intimacy is about authenticity, right? But we were taught not to show or talk about our true selves. We were taught to hide, deny, and deflect. How could we possibly know how to communicate in ways that are honest, open, and vulnerable? That's what I hope we learn by coming to couples therapy.

Understanding Sexual Orientation Change Efforts: Past and Present

Origins of SOCE

SOCE originated in the middle of the 19th century during a period in which being an LGBTQ person was considered both a crime and a medical illness (Katz, 1995). Pathologizing perspectives,

influenced by psychoanalytic theories and social stigma, continued until the middle of the 20th century (Drescher, 1998). A landmark study by psychologist Evelyn Hooker (1957) as well as follow-up research on personality and mental illness throughout the 1960s and 1970s found non-gay and gay persons to be relatively indistinguishable on levels of stability, social and vocational adaptiveness, judgment, and psychological adjustment (Freedman, 1971; Gonsiorek, 1982, 1991; Hart et al., 1978; Reiss, 1980).

Nonetheless, SOCE using psychoanalytic, cognitive, and behavioral techniques remained prevalent within mainstream psychology and psychiatry until the preponderance of research resulted in the removal of homosexuality from the American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* in 1973 (Drescher, 2003). Following the declassification of homosexuality as a mental disorder, the number of published research studies on SOCE declined as mainstream mental health professionals and social scientists began to view homosexuality as normal expression within the continuum of human sexuality (American Psychological Association, 2009).

The accumulation of empirical evidence led to resolutions opposing the depiction of sexual minorities as mentally ill by the American Psychiatric Association (1973), the American Psychological Association (Conger, 1975), the American Counseling Association (1998), the National Association of Social Workers (1997), and the American Psychoanalytic Association (1991). The American Medical Association (2018) and the American Academy of Pediatrics (1993) issued similar statements and the World Health Organization removed homosexuality from its list of disorders in 1992 (Nakajima, 2003). In November 1999, a primer on sexual orientation included a warning on the potential harm caused by reparative therapy. This primer was endorsed by the American Academy of Pediatrics, the American Association of School Administrators, the American Counseling Association, the American Federation of Teachers, the American Psychological Association, the American School Counselor Association, the American School Health Association, the Interfaith Alliance Foundation, the National Association of School Psychologists, the National Association of Secondary School Principals, the National Association of Social Workers, the National Education Association, and the School Social Work Association of America (Just The Facts, 2008).

Religion-Based SOCE

Despite the affirmative position taken by contemporary mental health professionals toward LGBTQ persons, SOCE continued to proliferate, largely fueled by religious groups (American Psychological Association, 2009). By necessity, reparative therapists and leaders of ex-gay ministries reinforce heterosexuality as normative, and promote a disease model that views same-sex attraction as psychopathology, developmental immaturity, and a deficit in moral character (Drescher, 1998). SOCE leaders discount the important contributions of LGBTQ persons within culture and throughout history, ignoring the reality of well-adjusted long-term same-sex couples and families who live, work, worship, and raise children within every community (Besen, 2003). My work with Sonia and Grace involved examining some of the deeply held negative views they had internalized about LGBTQ people. These views were significantly impacting their hopes and dreams for the future. Sonia recounted that her former Christian counselor told her "gay relationships don't last." I remember Sonia's sigh of relief in one session when I shared the results of research demonstrating the strengths and resilience often found in same-sex couples (Gottman et al., 2003).

Ex-gay ministries attempt to conquer same-sex attraction through a mix of prayer, Bible study, church attendance and worship sessions, group activities, self-help exercises, and educational classes. They forbid any form of intimate coupling or human sexuality other than heterosexual expression (Erzen, 2006). Ex-gay ministries range in modality from weekly individual and group sessions, to residential programs, which require clients to live communally for up to several months while undergoing a process geared to healing sexual "brokenness."

From 1998 to 2009, the conservative Christian organization Focus on the Family sponsored "Love Won Out" conferences to "promote the truth that change is possible for those who experience same-sex attractions." By the end of 2005, Love Won Out had reached an audience of 25,000 people across the U.S. (Gilgoff, 2007). Sonia's parents attended one of these conferences in Atlanta and obtained a referral list of Christian counselors and "ex-gay ministries." The counselor Sonia saw while trying to change her sexual orientation came from this list.

At their pinnacle, Exodus International included over 230 ex-gay ministries throughout the U.S. and Canada. Through the Exodus Global Alliance, they promoted the message "change is possible" and "freedom is possible through Jesus Christ." While most ex-gay ministries were rooted in fundamentalist Christianity, other programs were tied to different faith traditions, such as the now defunct JONAH (Jews Offering New Alternatives to Homosexuality), Courage for Catholics, and Evergreen International which has since merged with North Star for followers of The Church of Jesus Christ of Latter-day Saints. Programs to address specific populations emerged such as Witness Freedom Ministries for African Americans, Exodus Latinoamerica, Courage Latino and Camino de Salida for Latin Americans, and the now defunct Exodus Youth. Support groups include Homosexuals Anonymous modeled after 12-step programs, and Parents and Friends of Ex-Gays and Gays. In 2007, the president of the Southern Baptist Theological Seminary wrote:

> If a biological basis is found, and if a prenatal test is then developed, and if a successful treatment to reverse the sexual orientation to heterosexual is ever developed, we would support its use as we should unapologetically support the use of any appropriate means to avoid sexual temptation and the inevitable effects of sin.
>
> *(Mohler, 2007)*

Counseling-Based SOCE

In contrast to faith-based programs, there are licensed mental health professionals claiming to change same-sex attraction or to eliminate same-sex sexual behavior using psychotherapy. Despite social science research indicating otherwise, these practitioners routinely conceptualize homosexuality as a form of mental illness, developmental disorder, gender deficit, or addiction. Treatment protocols are predicated on disproven etiological theories that same-sex attraction results from family dysfunction, failure to establish healthy bonding with parental figures (particularly the same-gender parent), early traumatic events, or developmental arrest and intrapsychic conflict (Drescher, 1998). LGBTQ persons who struggle with guilt and shame may be drawn to these theories, hoping that resolution will remove homoerotic feelings, redeem them from mortal sin, and create a heteronormative future with loved ones.

The late Joseph Nicolosi coined the term "reparative therapy" to eliminate unwanted homosexuality (Nicolosi, 1991) and founded the National Association for the Research and Therapy of Homosexuality (NARTH) which has operated under the name of Alliance for Therapeutic Choice and Scientific Integrity since 2014. Nicolosi, along with others, further suggested that reparative therapy is a viable option for changing a person's gender identity (Psychvideos, 2009). Reparative therapists like Nicolosi often present themselves as secular psychologists. In fact, they are often connected to and supported by fundamentalist religious leaders and organizations (Besen, 2003). For example, Nicolosi served as a popular keynote speaker at Focus on the Family's Love Won Out conference. Nicolosi's extreme claims about homosexuality include: "There is no such thing as a homosexual…We are all heterosexual, but some heterosexuals have a homosexual problem," and

> We advise parents to use clear and consistent messages: 'We do not accept your effeminacy. You are a boy. God made you a boy. Being a boy is special.' When parents do this, especially fathers, they can turn their boys around.
>
> *(Nicolosi, 2003)*

Proponents of SOCE hailed a 2003 Columbia University study by the late Robert Spitzer, MD, claiming 200 individuals changed their orientation from homosexual to heterosexual. The story received wide media coverage in part because Spitzer played a key role in removing homosexuality from the list of mental disorders (Drescher, 2003). A number of researchers were critical of Spitzer's methodologies (Besen, 2006) and in 2004 Spitzer expressed concern regarding the distortions of his research in a videotaped interview (Lutes, 2005).

In 2009, the American Psychological Association published a comprehensive review of SOCE studies in the *Report of the Task Force on Appropriate Therapeutic Responses to Sexual Orientation.* According to this report, *sexual orientation* change is rare, whereas adaptation in *sexual orientation identity* by those with deeply held religious beliefs is a more common result of SOCE. *Sexual orientation* is defined as patterns of sexual, romantic, and affectional arousal. *Sexual orientation identity* "refers to acknowledgment and internalization of sexual orientation and reflects self-exploration, self-awareness, self-recognition, group membership and affiliation, culture, and self-stigma" (American Psychological Association, 2009, p. 30).

In 2013, Exodus International closed down after 37 years of operation and Alan Chambers issued a public apology, stating in part,

> I am sorry for the pain and hurt that many of you have experienced. I am sorry some of you spent years working through the shame and guilt when your attractions didn't change. I am sorry we promoted sexual orientation change efforts that stigmatized parents…I am profoundly sorry that many walked away from their faith and that some have chosen to end their lives.
>
> *(Payne, 2013)*

On June 26, 2015 the Supreme Court of the U.S. ruled that all states must grant same-sex marriages and recognize same-sex marriages granted in other states (*Obergefell v. Hodges*, 2015). This landmark case had a positive and dramatic impact on social acceptance. As of 2019, 63% of Americans support same-sex marriage and 63% believe that homosexuality is morally acceptable (Gallup, 2019). Sixty-six percent of white mainline Protestants and 61% of Catholics now support same-sex marriage (Pew Research Center, 2019).

As of this publication, several states and territories have banned conversion therapy with minors: California in 2012; New Jersey in 2013; DC in 2014; Oregon and Illinois in 2015; Vermont in 2016; Rhode Island, New Mexico, Connecticut, and Nevada in 2017; Washington, Maryland, Hawaii, New Hampshire, and Delaware in 2018; New York, Massachusetts, Maine, Colorado, and Puerto Rico in 2019 (Movement Advancement Project, 2019). Other states are likely to follow, yet this will not halt the emergence of new SOCE programs. For example, in January 2019 the Archdiocese of Denver launched a SOCE program in Catholic churches that could still be practiced since Colorado's legal ban applies only to licensed, certified, or registered mental health professionals (Salzman, 2019). Many churches in the U.S. and abroad continue to offer various forms of self-help and ex-gay ministries.

As further evidence of growing public support of LGBTQ persons, Amazon announced in July 2019 that it would no longer sell books by Joseph Nicolosi on its site, including "A Parent's Guide to Preventing Homosexuality" (Aviles, 2019). Some critics consider this to be censorship,

whereas others noted that Amazon also removed titles promoting the drinking of a bleach-like substance to "cure" Autism and suggest it is in the best interest of public health to remove untested, unproven pseudo-science that is potentially harmful.

Despite advances in social acceptance, 67% of LGBTQ youth report that someone tried to convince them to change their sexual orientation, and those who have undergone conversion therapy are more than twice as likely to attempt suicide as youth who did not (The Trevor Project, 2019). When parents send their teenagers to therapists and religious leaders for SOCE, there is often an increase in depression and suicidal thoughts or attempts, as well as less educational achievement and less income (Ryan et al., 2018). The practice of reparative therapy and the international proliferation of ex-gay ministries will continue until societies and religions worldwide refuse to tolerate prejudice, and sexual minorities are allowed to express their identities openly without fear of coercion, oppression, and discrimination. Until then, therapists working with SOCE survivors and other victims of heterosexism should provide client education on the scientific facts, engage in social justice advocacy, and promote empowerment strategies to develop the client's capacity for self-advocacy (Crethar et al., 2006). Practitioners must use, according to Goodman and colleagues (2004, p. 795), "scholarship and professional action designed to change societal values, structures, policies, and practices such that disadvantaged or marginalized groups gained increased access to the tools of self-determination." Since, like Sonia, the majority of SOCE survivors come from conservative religious backgrounds (Wolkomir, 2006), affirmative therapists can provide information about religious communities in their local area that welcome and affirm sexual minorities (Dahl & Galliher, 2009). Mental health professionals should assist clients in the full integration of their sexual and religious identities but should refrain from practices that are unethical, have no empirical support, and are likely to harm clients (Finnerty et al., 2017).

Harmful Effects of Sexual Orientation Change Efforts

Licensed mental health professionals aspire to Hippocrates injunction to "do no harm." Mandated by the ethical guidelines of their respective professional associations, mental health professionals are required to reject interventions, interpretations, and techniques that might negatively impact the emotional, cognitive, and spiritual well-being of those under their care (American Association for Marriage and Family Therapy, 2015; American Counseling Association, 2014; American Psychiatric Association, 2013; American Psychological Association, 2017; National Association of Social Workers, 2017).

The literature describes harmful effects of SOCE such as anxiety, depression, fear of intimacy, sexual dysfunction, negative self-concept and personal unworthiness, shame, self-destructive behavior, PTSD, and suicidal ideation (Haldeman, 2001; Nicolosi et al., 2000; Shidlo & Schroeder, 2002; Tozer & Hayes, 2004; Whitman et al., 2013). These negative effects are exacerbated by the stigma impacting the daily lives of LGBT people (Herek, 2009) and are perpetuated by heterosexual privilege.

Two proponents of reparative therapy, Don Schmierer (Exodus International) and Caleb Lee Brundidge (International Healing Foundation), took part in a conference in Uganda promoting Christianity and the ex-gay movement in March of 2009. Schmierer and Brundidge joined conservative preacher Scott Lively and the presence of these Americans influenced a bill introduced in Uganda's Parliament calling for the prosecution of and death penalty for homosexuals (Alsop, 2009).

The promotion of genocide against LGBTQ persons by proponents of SOCE is not an exaggeration. Scholars Sue Spivey and Christine Robinson, Department of Sociology and Anthropology at James Madison University, conducted a comprehensive and systematic analysis of written and oral material from NARTH, Exodus International, Exodus Global Alliance, and Focus on the Family. Their findings in the international journal *Genocide Studies and Prevention* indicate that rhetoric of these organizations is consistent with the definition of genocide listed in articles II(b)-(e) of the 1948 United Nations Convention on the Prevention and Punishment of

the Crime of Genocide (UNCG). Included among the strategies employed to eliminate groups of unwanted persons are to create "us-them" thinking that divides the world into "us" (Christians) and "them" (homosexuals), and to define members of a community as if they are objects, or in terms of behaviors, or conditions that can then be demonized and blamed for a variety of social evils (Spivey & Robinson, 2010).

Individuals often leave SOCE treatment feeling harmed. Peterson Toscano spent 17 years and $30,000 trying to change his sexual orientation. He discussed his experience stating,

> One day I woke up exhausted from it all. It was like I woke up out of a coma, and for the first time in years, I was thinking with my own mind. I asked myself the critical question, 'What the hell are you doing? This is crazy. You're destroying yourself. It's not working.' I realized I was in a coma all those years—a Biblically induced, culturally Christian coma.
>
> *(Moore, 2007)*

In 2007, former leaders of the ex-gay movement came together in Los Angeles to issue a public apology for the damage they inflicted on others. Michael Bussee (co-founder of Exodus International), Darlene Bogle (former director of an Exodus Ministry), and Jeremy Marks (founder of Courage UK) included the following in their remarks:

> As former leaders of ex-gay ministries, we apologize to those individuals and families who believed our message that there is something inherently wrong with being gay, lesbian, bisexual, or transgender. Some who heard our message were compelled to try to change an integral part of themselves, bringing harm to themselves and their families. Although we acted in good faith, we have since witnessed the isolation, shame, fear, and loss of faith that this message creates. We apologize for our part in the message of broken truth we spoke on behalf of Exodus and other organizations. We call on former ex-gay leaders to join the healing and reconciliation process by adding their names to this apology. We encourage current leaders of ex-gay programs to have the courage to evaluate the fruit of their programs. We ask them to consider the long-term effects of their ministry.
>
> *(Soulforce & Beyond Ex-Gay, 2007)*

In 2019, 24 former ex-gay leaders wrote an open letter detailing the emotional damage they witnessed in such programs. It included the following excerpt:

> As former "ex-gay" leaders, having witnessed the incredible harm done to those who attempted to change their sexual orientation or gender identity, we join together in calling for a ban on conversion therapy. It is our firm belief that it is much more productive to support, counsel, and mentor LGBTQ individuals to embrace who they are in order to live happy, well-adjusted lives.
>
> *(National Center for Lesbian Rights, 2014)*

The APA Task Force report encourages affirmative therapists to reduce harm of SOCE by grounding their professional actions in the following scientific facts:

- No empirical studies nor peer-reviewed research supports theories attributing same-sex sexual orientation to family dysfunction or trauma (American Psychological Association, 2009, p. 54).
- Same-sex sexual attractions, behavior, and orientations per se are normal and positive variants of human sexuality—in other words, they are not indicators of mental or developmental disorders.

- Same-sex sexual attractions and behavior can occur in the context of a variety of sexual orientations and sexual orientation identities.
- Gay men, lesbians, and bisexual individuals can live satisfying lives and form stable, committed relationships and families that are equivalent to those of heterosexual individuals in essential respects.

Helping SOCE Survivors Inside the Therapy Office

Collaborative Therapy

Affirmative therapy is not a specific therapeutic model, but rather a collection of ideas for reflecting and thinking about clinical practice with diverse populations. Still, one counseling model well suited for survivors of SOCE is Collaborative Therapy (CT), also referred to as Collaborative-Dialogical Practices. CT is a postmodern approach based on the tenet that dialogue and social construction shape our experiences of reality (Anderson, 1997; Anderson & Gehart, 2007). CT challenges the hierarchical and "therapist-as-expert" foundations of some other psychotherapy models, including those used in SOCE programs. Collaborative therapists seek conversations with clients that help them move away from problem-saturated and oppressive stories, and toward "re-authoring" their personal stories with more hopeful, preferred, and previously unrecognized possibilities. The client's voice is privileged in psychotherapy sessions and the language used by the therapist is generative, respectful, and welcoming of complexity. As described by McDonough and Koch (2007, p. 168):

> Collaborative therapy embraces the following premises: the therapist facilitates therapy from a non-hierarchical, not-knowing position; she invites multiple perspectives into conversations to promote a shared inquiry into clients' dilemmas; and she creates space for rich dialogue and conversation, both in and out of the consultation room.

Using this non-judgmental and conversational stance, I helped Sonia and Grace to reduce shame and increase pride in their many intersecting identities. My goal was to empower their relationship by providing psychoeducation and bridging gaps in support by assisting them in finding other LGBTQ couples in the community for connection and healthy role modeling. Since spiritual trauma (Stone, 2013) is an essential part of their relational story, I carefully attended to power differentials in our sessions and frequently invited Sonia and Grace to share their stories and voice their feelings, ideas, and perspectives. Victims of spiritual abuse often hope to rebuild a healthy spiritual life and find a community of faith that is welcoming and affirming of all their identities (Super & Jacobson, 2011). I referred Sonia and Grace to several LGBTQ-friendly churches in the local area, and helped them set up a meeting with an affirming pastor. After attending several services, they chose to join Metropolitan Community Church (MCC) because many of the individuals and couples in the congregation were also queer people of color. These actions empowered Sonia and Grace, which is a vital quality of affirmative LGBTQ counseling (Association of Multicultural Counseling and Development, 2015).

Culture-Centered Counseling

In contrast to the hierarchical and heteronormative messages inherent in SOCE programs, affirmative therapists support the survivor in the development and self-acceptance of all their intersectional identities. Since heterosexism is pervasive in the culture, and is the primary force behind SOCE, affirmative therapists should first assess their own heteronormative biases, including those that may exist in their preferred theoretical model. Therapists working with the LGBTQ community and survivors of SOCE should examine three constructs of heterosexism: heteronormative assumptions, institutional heterosexism, and heterosexual privilege.

Table 25.1 Examining Heterosexism Constructs

Construct Definitions	Questions and Examples
HETERONORMATIVE ASSUMPTIONS are the unconscious beliefs and expectations that reinforce heterosexuality and heterosexual relationships as the norm.	When I first meet a client, do I assume they are heterosexual? What internal reactions do I have when I see an LGBTQ person expressing physical affection? What did I learn from my family of origin about LGBTQ persons?
INSTITUTIONAL HETEROSEXISM is the societal policies and actions by governments, healthcare systems, educational systems, and other institutions that promote heterosexual behavior and relationships above non-heterosexual ones, exclude or discriminate against LGBTQ people, and privilege and grant benefits to heterosexuals.	"Religious Freedom" laws allowing business owners to refuse service to LGBTQ customers and federal laws that do not explicitly prohibit employment discrimination based on sexual orientation or gender-identity. Medical and school forms that ask about the mother and father of the child. Church and social events are organized around assumptions of heterosexuality. Children with same-sex parents rarely see their families represented in children's books.
HETEROSEXUAL PRIVILEGE is the unearned civil rights, social benefits, and advantages granted to individuals based entirely on their heterosexuality.	Have you ever worried that you might be "outed" as heterosexual? Have you ever feared you might be rejected by family, friends, employer, or church simply because you are "straight"? Have you ever wondered why God made you heterosexual? Have you paid thousands of dollars to a therapist or spent hundreds of hours in a religious program trying to change your sexual orientation from straight to gay?

Table 25.1, modified from the work of McGeorge and Carlson (2011), demonstrates important concepts for consideration.

In addition to dismantling heterosexism, affirming therapists must consider how other marginalized statuses might also impact the needs of clients seeking their assistance. Heterosexism is significantly compounded by racism and white privilege, and queer people of color (QPOC) may be subjected to multiple layers of oppression that place them at higher risk for depression and suicide (Sutter & Perrin, 2016). QPOC are at risk for additional distress, since they may not feel accepted by either the LGBTQ community or communities of color while coming out and trying to integrate both identities (Ghabrial, 2016). Queer African American women may be further subjected to discrimination due to multiple intersecting identities of sexual orientation, race, and gender (Brooks et al., 2008). In addition to race and gender, affirming therapists should help LGBTQ clients to disentangle the marginalization resulting from their age and generation, disability status, religion or spirituality, socioeconomic status, and immigrant or indigenous status (Filmore & Ginicola, 2017).

Sonia and Grace experience microaggressions nearly every day, both individually and as a couple. They are acutely aware of their multiple minority statuses. "The first thing people see when I walk out the door is my color, the gay thing we deal with later," said Sonia during the first therapy session. I maintained a curious and respectful stance, and asked if either of them had concerns about working with me, given my privilege as a white male. Sonia stated that the question made her feel more comfortable since matters related to race and gender were apparently

on my radar. I promised to pay attention to this dynamic during counseling sessions and make every effort to engage them through all their intersectional identities. They reported that finding a Black lesbian or transgender therapist had proven to be difficult. The three of us agreed to bring in outside consultants (other therapists) to address various needs if we co-determined that doing so might be helpful. Throughout my work with Sonia and Grace, I frequently inquired about these intertwined identities by asking questions such as

> What are some of the ways you've been misunderstood or treated poorly because of your gender or race? What are some of the false or misleading assumptions others have made about your relationship? What did the Black church teach you about spirituality and religion, and which of those beliefs are important to you today? What do your white friends need to know about your experience as a mixed-race lesbian and trans couple? What are the ways in which your multiple identities have made your relationship stronger and more resilient?

Strengths-Based Perspective

Many LGBTQ individuals, couples, and families lead successful lives, form healthy relationships, and exemplify remarkable resilience despite the social, legal, and religious forces that discriminate against them. Grafsky and Nguyen (2011, p. 196) state, "We assert that LGBTQ+ families should not be seen as nontraditional, atypical, unnatural, abnormal or rare. Instead, we assert that they should be seen as extraordinary—beyond what is ordinary, exceptional in character, noteworthy and remarkable." The recorded stories of dozens of long-term LGBTQ couples, available for listening on the Q Marriage Mentors podcast, demonstrate the strengths, creativity, and resilience in these relationships (Lutes, 2018).

A turning point in my therapy with Sonia and Grace was a conversation in which I simply remarked "Your ability to maintain a romantic relationship, excel in your careers, maintain positive friendships, sing in the choir, and volunteer at a local food bank each week is amazing." Seemingly bewildered, Grace asked "What do you mean?" I responded by noting they have managed these accomplishments despite the lack of familial and social support that others with more privilege might take for granted. Like many clients, Sonia and Grace had been telling their story through a problem-saturated and shame-based lens. At the next session, they reported that my reflection the week before had lifted their moods and sparked a long conversation over coffee the next morning. As a result of that conversation, Sonia and Grace started gently challenging the negative self-talk that had become engrained in each of their narratives, and began infusing their dialogue with intentional reflections about their strengths and accomplishments as a couple.

Affirmative therapy has been described by the American Association for Marriage and Family Therapy, California Division (2014) as "an approach to therapy that embraces a positive view of lesbian, gay, bisexual, transgender, and queer identities and relationships and addresses the negative influences homophobia, transphobia, and heterosexism have on the lives of LGBTQ clients." Affirmative therapists use strengths-based approaches to move beyond simple tolerance of LGBTQ clients. Instead, they embrace acceptance, admiration, affirmation, and appreciation (Riddle, 1994) as they foster genuine connection and empower their clients toward self-agency.

Helping SOCE Survivors Outside the Therapy Office

In addition to culturally competent clinical practice in their offices, therapists have a professional and social responsibility to assist those who are disenfranchised through social justice advocacy outside their therapy offices (Ibrahim & Heuer, 2016). I collaborated with many others to initiate work with SOCE survivors at two unique conferences. The *Ex-Gay Survivor Conference* in 2007

and the *Anti-Heterosexism Conference* in 2009 brought survivors and allies together to create space for storytelling, healing, and community building and to educate the public about harm caused by SOCE. At these conferences we talked with and listened to over 200 survivors from the U.S., the U.K., and Australia as they co-constructed new possibilities for their lives. Since our intention was to follow the lead of the survivors, we began with a "chalk talk" in which conference participants engaged in a "visual conversation," writing words, phrases, or images about their SOCE on a wall-sized piece of paper. I remember feeling deeply moved as I watched this silent exercise unfold. Here some of the poignant phrases shared by survivors:

- I thought I was changing. In reality, I had walled away my sexuality.
- I helped create Exodus in 1976. Please forgive me.
- I failed God.
- I bore false witness.
- My family can only love the mask they give me to wear.
- I was 16 when my small group leader molested me.
- I talked to him again last night. I think I'm falling in love…guess my exorcism didn't work.
- I am here because young people are taught to be uncomfortable in their own skin and fear what will become of their lives.
- Heterosexism is the indirect, unconscious ideology that we breathe in like poison in the air, telling us that heterosexuality is somehow superior or more desirable than any other way of being. BTW, I love heterosexuals!

Stories told at these conferences had a clear, consistent theme: reparative therapies and ex-gay ministries cause more harm than good. Although outweighed by the harm, survivors reported a few benefits to their SOCE such as decreased social isolation, increased empathy, and spiritual support. These are consistent with both the literature on SOCE (Beckstead & Morrow, 2004), and with the literature on the common beneficial factors across psychotherapy models (Norcross, 2002).

We invited ex-gay leaders and reparative therapists to sit down for dialogue and shared inquiry about SOCE, welcoming complexity and all relevant voices into the conversation, despite differences in perspective. A small number of Exodus leaders accepted this invitation and heard the painful survivor stories (Beyond Ex-Gay, 2007). Survivor Jallen Rix, in his book *Ex-Gay No Way* (2010, p. 232), writes: "Although life is always full of challenges and I'm still learning to let go and receive, I can now go days, weeks, and whole seasons feeling great about myself, with little shame in sight." Jallen's story, along with others, reminds me of my ethical obligation to serve dual roles. Inside the psychotherapy office, my job is to assist in healing of those traumatized by SOCE and heterosexual privilege. Outside the therapy office, my duty is to advocate for those who have been marginalized and oppressed.

Conclusion

Affirmative therapy with survivors of SOCE encompasses understanding the history of trauma caused by social and religious stigma, and an appreciation of the intersectional identities such clients bring into the therapy office. Therapists assisting SOCE survivors must explore and examine their own areas of privilege and strive to work from a culture-centered, collaborative, and strengths-based perspective that helps survivors re-author their stores and move toward increased self-respect and self-advocacy. Clinicians should consider visual displays in their office that demonstrate safety and acceptance of LGBTQ and other marginalized identities (Heck et al., 2013). Therapists might ask themselves "What does my website, social media, reading material in the waiting room, and intake paperwork communicate about me to this population?" Affirmative therapists of all therapeutic orientations

have a professional and ethical responsibility to serve as social change agents, in and out of the therapy office. Furthermore, affirmative therapists have an important role in actively challenging prejudice, discrimination and the inequitable distribution of social power in regard to sexual orientation, gender, gender identity, race, ethnicity, age, disability, religion, and social class.

References

Alsop, Z. (2009, December 10). Uganda's anti-gay bill inspired by the U.S. *TIME*. http://content.time.com/time/world/article/0,8599,1946645,00.html

American Academy of Pediatrics. (1993). Homosexuality and adolescence. *Pediatrics, 72*(2), 249–250.

American Association for Marriage and Family Therapy. (2015). *Code of ethics.* https://www.aamft.org/imis15/content/legal_ethics/code_of_ethics.aspx

American Association for Marriage and Family Therapy, California Division. (2014). *LGBT affirmative therapy: Tips for creating a more lesbian, gay, bisexual, transgender, and gender inclusive practice from the AAMFT Queer Affirmative Caucus.*

American Counseling Association. (2014). *ACA Code of Ethics*. https://www.counseling.org/knowledge-center/ethics#2014code

American Counseling Association Governing Council. (1998). *Affirmative resolution on lesbian, gay, and bisexual people.* American Counseling Association Governing Council.

American Medical Association. (2018). Policy on the health care needs of lesbian, gay, bisexual, transgender, and queer populations (H-160.991). https://policysearch.ama-assn.org/policyfinder/detail/Health%20Care%20Needs%20of%20Lesbian, %20Gay, %20Bisexual, %20Transgender%20and%20Queer%20Populations%20H-160.991?uri=%2FAMADoc%2FHOD.xml-0-805.xml

American Psychiatric Association. (1973). *Homosexuality and civil rights.* Position statement approved by the Board of Trustees.

American Psychiatric Association. (2013). *The principles of medical ethics with annotations especially applicable to psychiatry*. https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Ethics/principles-medical-ethics.pdf

American Psychoanalytic Association. (1991). *Position statement: Homosexuality.*

American Psychological Association. (2009). *Report of the American Psychological Association task force on appropriate therapeutic responses to sexual orientation.* Task Force on Appropriate Therapeutic Responses to Sexual Orientation. https://www.apa.org/pi/lgbt/resources/therapeutic-response.pdf

American Psychological Association. (2017). *Ethical principles of psychologists and code of conduct.* https://www.apa.org/ethics/code#

Anderson, H. (1997). *Conversations, language, and possibilities: A postmodern approach to therapy*. Basic Books.

Anderson, H., & Gehart, D. (Eds.). (2007). *Collaborative therapy: Relationships and conversations that make a difference.* Routledge.

Association of Multicultural Counseling and Development. (2015). *Multicultural and social justice counseling competencies*. https://www.counseling.org/knowledge-center/competencies

Aviles, G. (2019, July 3). *Amazon removes books by controversial 'father of conversion therapy.'* https://www.nbcnews.com/feature/nbc-out/amazon-removes-controversial-books-father-conversion-therapy-n1026446

Beckstead, A. L., & Morrow, S. L. (2004). Mormon clients' experiences of conversion therapy: The need for a new treatment approach. *The Counseling Psychologist, 32*(5), 651–690. https://doi.org/10.1177/0011000004267555

Besen, W. (2003). *Anything but straight: Unmasking the scandals and lies behind the ex-gay myth.* Harrington Park Press.

Besen, W. (2006). Political science. In J. Drescher & K. J. Zucker (Eds.), *Ex-gay research: Analyzing the Spitzer study and its relation to science, religion, politics, and culture* (pp. 291–308). Haworth.

Beyond Ex-Gay. (2007). https://beyondexgay.com/article/apology.html

Brooks, L., Inman, A., Malouf, M., Klinger, R., & Kaduvettoor, A., (2008). Ethnic minority bisexual women: Understanding the invisible population. *Journal of LGBT Issues in Counseling, 2*(4), 260–284. https://doi.org/10.1080/15538600802501953

Conger, J. J. (1975). Proceedings of the American Psychological Association, Incorporated, for the year 1974: Minutes of the annual meeting of the Council of Representatives. *American Psychologist, 30*(6), 620–651. https://doi.org/10.1037/h0078455

Crethar, H. C., Bradley, L. J., Lewis, J., Toporek, R., & Tripp, F. (2006, April). *Promoting systemic change through advocacy competence* [Presentation]. Annual American Counseling Association Convention, Montreal, Canada.

Dahl, A. L., & Galliher, R. V. (2009). LGBQQ young adult experiences of religious and sexual identity integration. *Journal of LGBT Issues in Counseling, 3*(2), 92–112. https://doi.org/10.1080/15538600903005268

Drescher, J. (1998). *Psychoanalytic therapy and the gay man*. Analytic Press.

Drescher, J. (2003). The Spitzer study and the culture wars. *Archives of Sexual Behavior, 32*(5), 431–432.

Erzen, T. (2006). *Straight to Jesus: Sexual and Christian conversions in the ex-gay movement.* University of California Press. https://doi.org/10.1525/9780520939059

Filmore, J., & Ginicola, M. (2017). Counseling an LGBTQI+ person of color. In M. Ginicola, C. Smith, & J. Filmore (Eds.), *Affirmative counseling with LGBTQI+ people* (pp. 271–284). American Counseling Association. https://doi.org/10.1002/9781119375517.ch20

Finnerty, P., Kocet, M., Lutes, J., & Yates, C. (2017). Disaffirming therapy: The ascent and descent of sexual orientation change efforts. In M. Ginicola, C. Smith, & J. Filmore (Eds.), *Affirmative counseling with LGBTQI+ people* (pp. 87–96). American Counseling Association. https://doi.org/10.1002/9781119375517.ch8

Freedman, M. (1971). *Homosexuality and psychological functioning*. Brooks/Cole.

Gallup. (2019). *Gay and lesbian rights.* https://news.gallup.com/poll/1651/gay-lesbian-rights.aspx

Ghabrial, M. A. (2016). "Trying to figure out where we belong." Narratives of racialized sexual minorities on community, identity, discrimination, and health. *Sexuality Research & Social Policy, 14*(1), 42–55. https://doi.org/10.1007/s13178-016-0229-x

Gilgoff, D. (2007). *The Jesus machine: How James Dobson, Focus on the Family, and evangelical Americans are winning the culture war.* St. Martin's Press.

Gonsiorek, J. C. (1982). Results of psychological testing on homosexual populations. *American Behavioral Scientist, 25*(4), 385–396. https://doi.org/10.1177/000276482025004004

Gonsiorek, J. C. (1991). The empirical basis for the demise of the illness model of homosexuality. In J. C. Gonsiorek & J. D. Weinrich (Eds.), *Homosexuality: Research implications for public policy* (pp. 115–136). Sage. https://doi.org/10.4135/9781483325422.n8

Goodman, L. A., Liang, B., Helms, J. E., Latta, R. E., Sparks, E., & Weintraub, S. R. (2004). Training counseling psychologist as social justice agents: Feminist and multicultural principles in action. *The Counseling Psychologist, 32*(6), 793–837. https://doi.org/10.1177/0011000004268802

Gottman, J. M., Levenson, R. W., Swanson, C., Swanson, K., Tyson, R., & Yoshimoto, D. (2003). Observing gay, lesbian and heterosexual couples' relationships: Mathematical modeling of conflict interaction. *Journal of Homosexuality, 45*(1), 65–91. https://doi.org/10.1300/J082v45n01_04

Grafsky, E., & Nguyen, H. (2011). Affirmative therapy with LGBTQ+ families. In S. Browning & K. Pasley (Eds.), *Contemporary families: Translating research into practice* (pp. 196–212). Routledge.

Haldeman, D. C. (2001). Therapeutic antidotes: Helping gay and bisexual men recover from conversion therapies. *Journal of Gay and Lesbian Psychotherapy, 5*(3–4), 117–130. https://doi.org/10.1080/19359705.2001.9962288

Hart, M., Roback, H., Tittler, B., Weitz, L., Walston, B., & McKee, E. (1978). Psychological adjustment of nonpatient homosexuals: Critical review of the research literature. *Journal of Clinical Psychiatry, 39,* 604–608.

Heck, N. C., Flentje, A., & Cochran, B. N. (2013). Intake interviewing with lesbian, gay, bisexual, and transgender clients: Starting from a place of affirmation. *Journal of Contemporary Psychotherapy, 43*(1), 23–32. https://doi.org/10.1007/s10879-012-9220-x

Herek, G. M. (2009). Sexual stigma and sexual prejudice in the United States: A conceptual framework. In D. A. Hope (Ed.), *Nebraska symposium on motivation: Contemporary perspectives on lesbian, gay, and bisexual identities* (Vol. 54, pp. 65–111). Springer. https://doi.org/10.1007/978-0-387-09556-1_4

Hooker, E. A. (1957). The adjustment of the male overt homosexual. *Journal of Projective Techniques, 21*(1), 18–31. https://doi.org/10.1080/08853126.1957.10380742

Hunt, M. E. (2007). Eradicating the sin of heterosexism. In M. M. Ellison & J. Plaskow (Eds.), *Heterosexism in contemporary world religion: Problem and prospect* (pp. 155–176). Pilgrim Press.

Ibrahim F. A., & Heuer, J. R. (2016). Incorporating social justice and advocacy in counseling and psychotherapy. In *Cultural and social justice counseling. International and cultural psychology*. Springer. https://doi.org/10.1007/978-3-319-18057-1_5

Just the Facts Coalition. (2008). *Just the facts about sexual orientation and youth: A primer for principals, educators, and school personnel.* American Psychological Association. https://www.apa.org/pi/lgbt/resources/just-the-facts

Katz, J. (1995). *Gay American history: Lesbians and gay men in the United States*. Thomas Crowell.

Lutes, J. (Producer). (2005). *Dear Dr. Dobson: An open video letter to Focus on the Family* [DVD]. http://www.soulforce.org

Lutes, J. (Producer). (2018). *Q Marriage Mentors* [Podcast]. https://podcasts.apple.com/us/podcast/q-marriage-mentors/id1425041500

McDonough, M., & Koch, P. (2007). Working with children and families in private practice: Shifting and overlapping conversations. In H. Anderson & D. Gerhart (Eds.), *Collaborative therapy: Relationships and conversations that make a difference* (pp. 167–181). Routledge.

McGeorge, C., & Carlson, T. (2011). Deconstructing heterosexism: Becoming an LGB affirmative heterosexual couple and family therapist. *Journal of Marital and Family Therapy, 37*(1), 14–26. https://doi.org/10.1111/j.1752-0606.2009.00149.x

Mohler, A. (2007, March 2). *Is your baby gay? What if you could do something about it?* [Blog post]. http://www.albertmohler.com/2007/03/02/is-your-baby-gay-what-if-you-could-know-what-if-you-could-do-something-about-it-2/

Moore, S. (2007, January 25–31). Ex-ex-gay: Peterson Toscano – A survivor of the ex-gay movement. *The Portland Mercury.*

Movement Advancement Project. (2019, July 6). *Conversion therapy laws.* http://www.lgbtmap.org/equality-maps/conversion_therapy

Nakajima, G. A. (2003). The emergence of an international lesbian, gay, and bisexual psychiatric movement. *Journal of Gay & Lesbian Psychotherapy, 7*(1/2), 165–188. https://doi.org/10.1300/J236v07n01_10

National Association of Social Workers. (1997). Policy statement: Lesbian, gay, and bisexual issues [approved by NASW Delegate Assembly, August 1996]. In *social work speaks: NASW policy* (4th ed., pp. 198–209). National Association of Social Workers.

National Association of Social Workers. (2017). *Code of ethics*. https://www.socialworkers.org/About/Ethics/Code-of-Ethics.aspx

National Center for Lesbian Rights. (2014). *Former founders, leaders, and promoters of the "ex-gay" movement denounce conversion therapy and stand with NCLR's #bornperfect.* https://www.nclrights.org/about-us/press-release/former-founders-leaders-and-promoters-of-the-ex-gay-movement-denounce-conversion-therapy-and-stand-with-nclrs-bornperfect/

Nicolosi, J. (1991). *Reparative therapy of male homosexuality*. Jason Aronson.

Nicolosi, J. (2003). Love won out [Tape recording]. *Focus on the Family Conference.* Oklahoma City, Oklahoma, United States.

Nicolosi, J., Byrd, A. D., & Potts, R. W. (2000). Retrospective self-reports of changes in homosexual orientation: A consumer survey of conversion therapy clients. *Psychological Reports, 86*(3 suppl), 1071–1088. https://doi.org/10.2466/pr0.2000.86.3c.1071

Norcross, J. C. (2002). *Psychotherapy relationships that work: Therapist contributions and responsiveness to patients.* Oxford University Press.

Obergefell v. Hodges. (2015, June 26). https://www.scotusblog.com/case-files/cases/obergefell-v-hodges/

Payne, E. (2013, July 8). *Group apologizes to gay community, shuts down "cure" ministry.* http://www.cnn.com/2013/06/20/us/exodus-international-shutdown/

Pew Research Center. (2019, May 14). *Attitudes on same-sex marriage*. https://www.pewforum.org/fact-sheet/changing-attitudes-on-gay-marriage/

Psychvideos. (2009, January 26). *Dr. Phil show - Little boy lost – Sparks fly among guests* [Video file]. http://www.youtube.com/watch?v=bXue5IknI2U&NR=1

Reiss, B. F. (1980). Psychological tests in homosexuality. In J. Marmor (Ed.), *Homosexual behavior: A modern reappraisal* (pp. 296–311). Basic Books.

Riddle, D. (1994). Attitudes toward differences: The Riddle Scale. In *Alone no more: Developing a school support system for gay, lesbian, and bisexual youth* (pp. 34–35). Minnesota State Department of Education.

Rix, J. (2010). *Ex-gay no way: Survival and recovery from religious abuse.* Findhorn Press

Ryan, C., Toomey, R., Diaz, R., & Russell, S. (2018). Parent-initiated sexual orientation change efforts with LGBT adolescents: Implications for young adult mental health and adjustment. *Journal of Homosexuality, 67*(2), 159–173. https://doi.org/10.1080/00918369.2018.1538407

Salzman, J. (2019, January 28). *Colorado's ban on conversion therapy won't stop the Catholic Church.* https://rewire.news/article/2019/01/28/colorados-ban-on-conversion-therapy-wont-stop-the-catholic-church/

Shidlo, A., & Schroeder, M. (2002). Changing sexual orientation: A consumers' report. *Professional Psychology: Research and Practice, 33*(3), 249–259. https://doi.org/10.1037/0735-7028.33.3.249

Soulforce & Beyond Ex-Gay. (2007). *Former ex-gay leaders apologize.* https://www.youtube.com/watch?v=aDiYeJ_bsQo

Spitzer, R. L. (2003). Can some gay men and lesbians change their sexual orientation? Two hundred participants reporting a change from homosexual to heterosexual orientation. *Archives of Sexual Behavior, 32*(5), 403–417. https://doi.org/10.1023/A:1025647527010

Spivey, S. E., & Robinson, C. M. (2010). Genocidal intentions: Social death and the ex-gay movement. *Genocide Studies and Prevention, 5*(1), 68–88. https://doi.org/10.3138/gsp.5.1.68

Stone, A. M. (2013). Thou shalt not: Treating religious trauma and spiritual harm with combined therapy. *Group, 37*(4), 323–337. https://doi.org/10.13186/group.37.4.0323

Super, J. T., & Jacobson, L. (2011). Religious abuse: Implications for counseling lesbian, gay, bisexual, and transgender individuals. *Journal of LGBT Issues in Counseling, 5*(3–4), 180–196. https://doi.org/10.1080/15538605.2011.632739

Sutter, M., & Perrin, P. B. (2016). Discrimination, mental health, and suicidal ideation among LGBTQ people of color. *Journal of Counseling Psychology, 63*(1), 98–105. https://doi.org/10.1037/cou0000126

The Trevor Project. (2019). *National survey on LGBTQ youth*. https://www.thetrevorproject.org/wp-content/uploads/2019/06/The-Trevor-Project-National-Survey-Results-2019.pdf

Tozer, E. E., & Hayes, J. A. (2004). Why do individuals seek conversion therapy? The role of religiosity, internalized homonegativity, and identity development. *The Counseling Psychologist, 32*(5), 716–740. https://doi.org/10.1177/0011000004267563

Whitman, J., Glosoff, H., Kocet, M., & Tarvydas, V. (2013, January 16). *Ethical issues related to conversion or reparative therapy.* https://www.counseling.org/news/updates/2013/01/16/ethical-issues-related-to-conversion-or-reparative-therapy

Wolkomir, M. (2006). *Be not deceived: The sacred and sexual struggles of gay and ex-gay Christian men.* Rutgers University Press. https://doi.org/10.36019/9780813539263

Taylor & Francis
Taylor & Francis Group
http://taylorandfrancis.com

26
Getting Personal
Queer Supervision

JANIE K. LONG, JACK GROTE, KYRA E. CITRON, MELANIE CAMEJO COFFIGNY, MANISH KUMAR, TYLER LIAN, and SHOM TIWARI

Introduction

Why queer supervision? Perhaps you grew up in a time or place where the word, queer, makes you cringe. Today working on a university campus with so many students who identify in a variety of ways (gay, bisexual, trans, genderqueer, non-binary pansexual, intersex, lesbian, questioning, and queer to name a few) for many of these students using the word queer is empowering. For them it usually means that you cannot put them in a stereotypical box assuming you have them figured out because of whom they date, whom they have sex with, how they perform their unique gender, etc. Queer also acknowledges the existence of fluidity in sexual attraction, one's sex, and one's gender identity. For the purposes of this chapter, queer supervision is associated with supervisors and supervisees who identify with diverse gender and sexual identities who do not consider themselves cisgender, single sex identifying, and/or heterosexual.

We chose the title, Queer Supervision, to honor what young people teach us every day and also to acknowledge that we need more inclusive language to keep pace with what we are learning. In this chapter, we use the word, queer, as an inclusive term that may constitute any number of sexual and/or gender identities. In moments we will use more specific labels to highlight a particular subset of the supervisee's queer identity. We believe it is important to use labels and language that our supervisees embrace.

Research regarding therapeutic efficacy has consistently shown that the therapeutic alliance accounted for the majority of the variance in treatment outcome, more so than the models or techniques being employed in therapy (Hubble et al., 1999; Sprenkle & Blow, 2004). Clients' assessments of the therapeutic relationship have been shown to be highly predictive of outcome (Miller et al., 2004). Congruence between clients' beliefs about the causes of their problems and the treatment approach offered resulted in stronger therapeutic alliance, reduced early dropout, and improved treatment outcomes (Duncan et al., 2009). While no studies have been conducted that demonstrate a strong supervisory alliance is key to successful therapeutic outcome, many authors writing about supervision have noted that the quality of relationship between the supervisor and the supervisee is crucial to the process of supervision. Several authors suggest that the supervisory relationship has more influence on the success of the process of supervision than any other factor (Aasheim, 2012; Alderfer & Lynch, 1986; Bradley & Ladany, 2010; Holloway, 1995). Kaiser (1992, p. 284) notes, "The supervisory relationship interacts in a dynamic way with what is taught in supervision…it is in fact, the medium through which how to do therapy is taught." Likewise, Orlinsky et al. (2005) posit that clinical supervision is the most important influence on clinical practice. Yet, Falender (2018) and others have noted that the nature of the supervisory relationship is an understudied phenomenon in psychological research.

DOI: 10.4324/9780429274626-32

Our focus in this chapter is on the supervisory relationship between queer supervisors and queer supervisees. This is not intended to restrict or ignore the contributions or abilities of cisgender and/or heterosexual supervisors and supervisees. All clinicians and supervisors, however they identify, can and ought to attend to multicultural complexities including those related to sexual and gender diversity. Multicultural complexity refers to "…the intricacies and convolutions represented by the intersections of multiple grounds of identity, privilege, and marginalization, which define social, historical, and political dimensions for different populations and communities" (Peters, 2017 p. 177). It is our belief that straight, cisgender supervisors and supervisees can embrace a supervision lens that is informed by queer theory and affirmative practice and can also promote the exploration of the intersectional nature of identities. But there are particular processes, opportunities, and challenges that can occur when both supervisor and supervisee identify as sexual and/or gender minorities. And we are finally—hopefully—in a moment of time that allows for the open study of these dynamics. It is not surprising that in the past there was a paucity of literature examining the relationship between queer supervisors and queer supervisees. Supervision is often tied to training/licensing in the mental health arena and training programs are housed within universities and accredited by national organizations that have not always been quick to support queer folx and social/practice policies that support them, like providing employment protection and banning the use of conversion therapy. Thus, many queer professionals and trainees remain hidden within their own training programs, and unfortunately, recent rollbacks of support for the LGBTQ+ community at the federal level may encourage queer people to continue doing so in order to maintain jobs.

Previously, Long and other colleagues have acknowledged some of the complexities of the particular supervision pairing of queer folks (Long & Bonomo, 2007; Long & Serovich, 2003; Storm et al., 2003). Many of those complexities are a result of the overall culture of training and supervision environments which are not affirming nor supportive as outlined above, but can also be attributed to the vast growth of our knowledge base along with the sheer speed of increased acceptance and visibility over the past 20 years. Most supervisors—queer and nonqueer—have grown up and trained within heteronormative systems and structures that are outdated and insensitive to younger generations. Imagine being a 55-year-old Southeast Asian female who self-identified as lesbian when she turned 40 years old, now supervising a 19-year-old Black trans man who identified in middle school, founded and led their school Queer People of Color group, and whose undergraduate honors thesis wove together the intersectional study of race and transgender identity from the 19th century to the present. Other challenges include the pressure placed on queer supervisors by the strong desire for queer role models despite major differences in culture, and varying levels of understanding or acceptance of newly evolving queer identities within the LGBTQ+ community. These differences can lead to expectations, miscommunications, and misunderstandings that cause tension and lead to alienation and isolation of the queer supervisee.

In addition to highlighting the joys and the challenges of this supervisory dyad, we provide case examples throughout the chapter to illustrate major concepts. We begin with a consideration of factors that are present in all supervisory relationships, acknowledged or not.

Factors in All Supervisory Relationships

Boundaries and Power

Multiple role relationships are often inevitable in supervision, as they evolve naturally from the nature of the supervisory context. Not only are supervisors responsible for supervisees' clinical work, they are also employer, professor, and/or the person who will sign off on their hours for licensure. Between queer supervisees and queer supervisors, there is additional potential for

multiple roles. This is so because oppression creates unique professional dilemmas that create a demand for queer professionals both as clinicians and as supervisors. In queer communities, which are often small, queer supervisees may lack strong positive queer role models. In such a small community, the queer supervisee may rely on the queer supervisor increasingly for support in a way that differs from heterosexual and gender-conforming supervisees because they are not facing the same heteronormative professional dilemmas and because they likely have more access to support networks. With regard to training programs, "faculty members are in a unique position of frequently being called on to offer counsel or guidance to students or trainees on personal matters" (Long & Serovich, 2003, p. 65). It would not be uncommon for a supervisee who is struggling with some aspect of their queer identity to reach out to a queer supervisor for guidance. While this action alone does not constitute a boundary violation, it does add layers of complexity to the supervision and requires thoughtful attention on the part of supervisors since boundary violations are "a process rather than a single event" (Peterson, 1992, p. 72). Thus, while one instance of guidance seeking may not be problematic, if that instance is combined with other boundary crossing behaviors (appearing on the supervisor's doorstep, becoming friends with the supervisor's significant other, etc.), it then could constitute a part of a problematic, potentially intrusive pattern.

It is also highly possible that a queer supervisor may know a queer supervisee through nonprofessional channels because of connections in the often-small LGBTQ+ community. This possibility is increasingly true in this day and age of social media. Supervisors and supervisees may be connected to many social media platforms increasing the likelihood of an overlap of professional and personal lives. They may be invited to and attend the same queer social events in the community in-person or online. They may even find they use the same dating apps as one another, taking what would have been a personal, anonymous situation and making it more awkwardly public.

There are both inherent dangers in multiple role relationships and the potential to enhance supervision. The dangers include (a) exploitation, (b) hierarchy, (c) secrecy, and (d) reduction of power. Exploitation occurs when a supervisor takes advantage of the supervisory relationship for another purpose beyond that of the training agenda. For example, assigning a supervisee the task of reviewing the literature in a specific content area as a part of their supervision assignment and then using that literature review for the supervisor's own writing purposes is plagiarism. Because the supervisee is dependent upon the supervisor on many levels (e.g., a grade, future references), they are vulnerable to being used for the supervisor's purposes.

Hierarchy involves a difference in power between supervisor and supervisee, with the supervisor being responsible for evaluations and gatekeeping. Given the hierarchical nature of supervision, supervisees are unable to freely and equally consent to the nonprofessional aspects of multiple relationships. Suppose a supervisor who is going through the tenure process begins relaying to the supervisee their challenges with the department chairperson who also serves as the supervisees dissertation advisor. This leaves the supervisee in an untenable position caught between supervisor and advisor unsure of how to proceed without jeopardizing their grade and perhaps their hours for licensure.

Secrecy can be used to cover manipulation and dishonesty, and is a flagrant abuse of power. One example involves a supervisor's dual agenda where one agenda is kept covert, under the guise of an official relationship. Imagine a supervisor is going away for a month of vacation and is hoping to find someone to housesit while away. They know one of their supervisees has done some housesitting because the supervisee mentioned it during supervision, and the supervisor wonders if they would be willing to housesit. The supervisor decides, however, it would be best not to ask them directly because they may be seen as exerting undue pressure on the supervisee. The supervisor decides to ask the supervisee if they would mind telling them how much they

charge per day to housesit, hoping that the supervisee might volunteer to do so. When the supervisor asks the supervisee their usual charges, they volunteer to housesit for them for free. The supervisor says that would be wonderful, and asks the supervisee to keep it between the two of them and no other students/faculty because it might be frowned upon by "uptight" others. The supervisee responds, "No problem." There are a number of potential conflicts of interest that could arise from such an arrangement.

Holding multiple roles with a supervisee can reduce the supervisor's power and alter the supervisor's capacity to evaluate. To continue the previous example, suppose that while housesitting, the supervisee discovers that the supervisor is in financial trouble when a bill collector calls. The supervisee promises not to tell others, but the supervisor feels the secrecy is contingent upon the grade they give the supervisee and feels beholden to the supervisee which may affect their ability to grade without bias.

It is important to remember that multiple role relationships also have the potential to enrich supervision. Among the many benefits, having multiple role relationships can:

- Increase the supervisor's sense of connection and personal responsibility toward the supervisee.
- Encourage both parties to be more authentic.
- Provide an opportunity for the supervisee to learn to manage complexity in relationships, which can be very helpful to learn within a safe setting.
- Help make the supervisory relationship more egalitarian than authoritative; the latter is a supervisory style that the research suggests can inhibit the supervision process (Long et al., 1996).
- Demystify the supervisor and make the supervisory relationship more grounded, real, and helpful.

Managing multiple roles can, however, increase the chance for ethical conundrums to occur that lend themselves to a blurring of boundaries as in the case below.

Case Example: Blurred Boundaries

Fausto is a Latinx trans man who is a clinical supervisor. He has been on hormones for five years and hopes to soon be cutting back on his dosage. He has been employed in his current position in the northeastern United States about three months. He was able to change his sex on his birth certificate just before he took this position so his employers know him as a cisman but not as a trans man. He is new to the area having moved from Miami to take the position where he had a large Latinx queer community including many other friends who also identified as trans men. With his move to a less diverse, less urban part of the country, he finds himself feeling very isolated and alone both as a member of the Latinx community and as a member of the trans community. He is happy to find a trans support group nearby and when he attends for the first time Fausto is very surprised to discover that one of his supervisees, Katalina, is one of the facilitators of the group. Katalina is Caucasian and a bit older than Fausto and also seems surprised to see him. She explains that she transitioned about 12 years ago and has been running the group for a number of years since then.

Fausto is alarmed to notice that he feels a loss of power on multiple levels. First, he feels uncomfortable having a supervisee who is older than him who also has more experience than he post-transition. Second, the fact that all the members of the support group and the facilitator are Caucasian is disempowering and uncomfortable.

He is now in the predicament of being in a supervisory relationship with someone who has several dominant culture advantages over him as well as now having knowledge about his personal life and identity that he hoped not to divulge to anyone related to his new position. As a

citizen of Honduras who is living in the United States as a permanent resident, recent political events have caused Fausto to feel even more sensitive to feelings of trauma related to the possibility of harassment or abuse (Alessi et al., 2017).

The supervisee assures him that she will never reveal his presence in the group. He feels stuck. Fausto does not feel that he can tell his employers at this juncture that he is a trans man, and he also cannot simply quit supervising the supervisee. He worries that if he continues to supervise her it could alter his ability to honestly evaluate her for fear that she may reveal his "secrets"; Fausto also is concerned that if he does indeed find himself censoring constructive criticism that he would offer to any other supervisees, he will be failing Katalina. Because of the inaccessibility of trans affirmative healthcare in the area, Fausto's avenues of support are limited. Nevertheless, he decides to leave the support group because at this point the only sensitive information Katalina has is that he is a trans man and if he stayed in the group, she would potentially know much more about him.

Another type of boundary confusion can occur in clinical supervision when a queer supervisee believes that the queer supervisor should "go easier" on them because they are queer and share a "background of oppression." This can create overt or subconscious expectations that the supervisor should not hold them to the same standards as other supervisees. It is also possible that some supervisees who are not queer may assume that because the supervisor shares a sexual orientation and/or gender identity with a supervisee, the supervisor may show some type of favoritism to that supervisee.

A related scenario occurs when the queer supervisor unconsciously tends to be harder and more demanding on a queer supervisee. This can happen as a result of wanting the supervisee to succeed in the future and the pressure that can build to ensure that particular bits of "queer" knowledge and socialization are successfully passed along especially because the supervisee is unlikely to get this elsewhere. Similarly, perhaps the supervisor is simply keenly aware of their role as a mentor in this instance and want to live up to that role. This type of unequal treatment can also occur as a defensive measure when a supervisor expects they have to ward off the criticisms or assumptions of non-queer colleagues or students who might feel threatened or left out of the connection that can occur between queer supervisors and queer supervisees.

Power

The obscuring of boundaries creates increased possibilities for power dynamics to be altered, which in turn increases the opportunity for boundary violations and abuses of power to occur. Supervisors hold power over supervisees in numerous ways. They may give grades, write recommendations for employment, have more knowledge and/or clinical experience, and feel more capable and entitled to negotiate the structure, rights, and responsibilities of supervision. While supervisees often do not have the skills to evaluate the competence of supervisors, they may be limited in choice of supervisors and feel afraid of the potential supervisors have to affect their future in numerous ways especially via licensing and employment. In addition to these potential sources of power related to position, experience, knowledge, skills, and connections, as well as sometimes socio-cultural power related to race, gender, and physical ability, queer supervisors also have their queerness as a potential type of influence with queer supervisees. A queer supervisor may be the first "out" professional with whom the queer supervisee has contact. This fact alone can give the supervisor immense influence in the life of the supervisee. If one adds to this scenario that the supervisor is more experienced and holds privilege in other ways (sex, race, class, education, etc.), a less experienced supervisee may place the supervisor on a pedestal. This place of power can be of help in guiding the supervisee but it also can mean that the supervisor is more likely to also hold greater potential to either fall from grace or disempower the supervisee in some way especially if the supervisor is not aware of their power.

An important source of power for the queer supervisor is the potential difference in power related to one's identity development, especially if the supervisee is new to recognizing a queer identity. An example of how a supervisee's uncertainty about her identity may impact supervision is seen in the following case example.

Case Example: Shifting Identities Chunhong, who is from China, is a supervisee who has recently fallen in love with a trans woman. Chunhong considers herself to be lesbian but wonders about that identity given that her new partner is trans. She has also recently learned that someone who is pansexual is attracted to all sexes and genders. Given this new information, Chunhong is questioning whether she wants to embrace an identity as pansexual rather than lesbian. Chunhong has heard that her Caucasian supervisor is a feminist lesbian who has a reputation for challenging supervisees who are questioning their own sexual orientation. Chunhong believes that if the supervisor does not value who she is as a sexual being then she may not also validate her clinical work. She decides before even meeting with the supervisor that she must never let the supervisor know anything about her orientation because she is likely to think less of her and/or not be open to who she is. Quek and Storm (2012) offer some thoughts on why Chunhong may remain silent. In this case the supervisor's position in the social hierarchy gives her power. They note, "Most Chinese respectfully submit to those perceived to be of a higher social position due to the belief that educational training and life experiences are indicative of wisdom and competency" (p. 46). Another factor in Chunhong's silence may be related to her feelings that she should be loyal to or submit to the will of someone who is above her in the supervisory role (Quek & Storm, 2012). Social harmony is also important in Chinese culture. "Social harmony encourages supervisors and supervisees to strive for harmonious, conflict free supervisory relationships. As a result, supervisees may be more guarded in expressing their opinions during supervision and highly cognizant of meeting professional expectations" (Quek & Storm, 2012, p. 48).

Before meeting the supervisor and influenced by her own cultural background, the supervisee has formed opinions of the supervisor based upon hearsay, stereotypes, ageism, race, etc. Whether any of the supervisee's fears are valid remains in question, yet the supervisee nonetheless fears questioning supervisory authority and worries how the power her supervisor has might be used to somehow invalidate her clinical abilities. She needs support and a willingness on the part of the supervisor to have open dialogue about the multiple differences between them and the resulting power differences. In this case the queer supervisor could help facilitate dialogue by openly discussing cultural values such as social hierarchy, filial subordination, and social harmony and how they might play out in supervision. The queer supervisor could also openly discuss the ramifications of how supervisors-supervisees talk to one another: who gains from the conversation, who is hurt by it, and who is silenced? What cultural values are sustained and which are undermined? It is also of the utmost importance that queer supervisors educate themselves related to the many ways that today's supervisees may identify their sexual and gender identities and take care not to discriminate against them if they do not understand them.

Openness

One's degree of openness about their own sexuality and/or gender identity can influence the experience of supervision in several ways. Let us consider first a person who is very open about gender and sexual identity. If the queer supervisee has a choice of supervisors, it is likely that they chose a queer supervisor, in part, because of their queer identity. The supervisee may be looking for someone who will provide queer-informed supervision or someone who can model for them what it means to be an out professional. If the supervisee is questioning or not open about sexual or gender identity, they may be somewhat terrified to work with supervisors who

are open about their queer identity. These supervisees may fear that an "out" supervisor will figure out their identity, "out" them to other supervisors or supervisees, or judge them lacking because they are not open, or differently queer.

Perhaps one of the most damaging things a queer supervisor can do is to simply ignore or minimize the potential relevance and import of their sexual orientation and/or gender identity to their queer supervisee. An open supervision context can be created that provides strong, clear, effective boundaries, which in turn models that issues of sexuality and gender are relevant clinical topics of conversation; that the supervisor is comfortable with who they are and capable of providing a model for one way to integrate a personal and professional life; and likewise, the supervisor can be accepting and affirming of the supervisee's identity. Conversely if a therapist minimizes or ignores identity especially out of their own discomfort, it creates destructive messages like sex and gender are off-limits in supervision; that the supervisor is uncomfortable with who they are, and, thus, who the supervisee is; or that one's personal attributes never make a difference in the therapy room. Any of these messages can create an unsafe environment for both supervisees and clients as important issues may be ignored that could bring harm to clients. It also sends a message to supervisees that openness in supervision is not important.

As noted elsewhere in this chapter, openness can be influenced by many factors including racial identity, religious affiliation, job situation, etc. Because a supervisor is queer does not mean they understand the intersectional experiences of other queer people. For example, being an openly gay, Christian, able bodied, white male is a fundamentally different experience than being an open trans woman (or man) Muslim who moves about the world in a motorized chair, and is a person of color.

Case Example: Ignoring One's Identity Manny, a Latinx queer supervisee, is preparing for supervision and reviewing his video. He thinks to himself, "I wonder if this teen could be struggling with his gender identity?" Manny knows Kieran (his Caucasian supervisor) identifies as trans, but they have never discussed it in supervision. Manny wonders why…maybe he's not comfortable with discussing personal issues, or maybe he thinks it is not appropriate to talk about himself, or maybe he's not comfortable talking about his identity. "I guess I best not 'go there' when we meet. I don't want him to think I am getting too personal or that I am questioning my identity." Kieran meanwhile is preparing for his upcoming supervision session with Manny by reviewing Manny's video with his client. As he reviews the video, Kieran notes that the client seems to have concerns about his gender identity. Kieran also notices that Manny seems uncomfortable in the session in ways he has never observed with Manny. Kieran decides that it would be important to talk about the possibility of a discussion about gender identity as something for Manny to explore with the client. Kieran realizes that he and Manny have never talked about gender identity. Kieran considers that Manny is coming from a different cultural background than his own and one that is often transphobic, racist, and xenophobic (Yamanis et al., 2018), thus making this conversation very important on a number of fronts. Kieran also recognizes the complexity and power in his position as a Caucasian trans-identified supervisor. He is mindful of wanting to create a supportive environment in which such a discussion can occur (Lapinski et al., 2018). At the next supervision session, Kieran decides to see if Manny will address gender identity as a possible client concern, and when Manny does not do so, he asks Manny if it he has considered it as a possible contributing factor to the client's anxiety. As a part of introducing the topic, Kieran also shares with Manny a bit about his own gender journey. Manny is more visibly relaxed by the end of the supervision session and thanks Kieran for opening the door a topic that was difficult for him to address.

Attributing Too Much Knowledge to Oneself or to a Queer Supervisee

Research about the LGBTQ+ community continues to document an ever evolving, ever growing, and diverse community. New information is becoming evident all the time. What we think we know today may no longer be true tomorrow. These facts are good news in that we know more about gender and sexuality than we have ever known before, but it is also a challenge for supervisors to stay current with a shifting landscape of knowledge and information. It would be understandable that queer supervisors would have gaps in knowledge about LGBTQ+ people. At times, supervisees may even have a more current knowledge base.

The other likely scenario is that queer supervisors may assume that queer supervisees know more than they do about the LGBTQ+ community and or relationships. Often one subgroup of the community knows very little about another. Naively, it is assumed that because someone is living a queer existence, others have the same experiences. Stereotyping happens as well because even members of the queer community have grown up in a biased culture. Being queer does not make one immune to heterosexism, homonegativity, biphobia, transphobia, sexism, racism, ageism, ableism, ethnocentrism, etc. Like many other supervisees, queer supervisees are also often fearful of allowing supervisors to know that they do not possess a broad knowledge base.

Case Example: Supervisor's Lack of Knowledge A queer supervisor is working with a queer supervisee who begins to refer to their client as "ze." *Ze* is a gender-neutral pronoun similar in use to the traditional *he or she*. At first the supervisor thinks the supervisee is simply trying to be humorous, but as they try to follow the conversation without becoming too distracted, they realize the supervisee is talking in a very serious way about a potentially suicidal client. The supervisor senses that the supervisee is using this word on purpose, but is uncertain why. The supervisor does not want to appear ignorant so they say nothing. The supervisor continues to use male pronouns that they believe to be appropriate for the client. Later the supervisor looks "ze" up on the Internet and finds that the supervisee was probably being very purposeful about the use of the word as a gender-neutral pronoun to describe a client who identifies as gender non-conforming. In the next supervision session, the supervisor admits their lack of knowledge and mistake to the supervisee and apologizes for being insensitive. This conversation allows the supervisee to then share with the supervisor their frustration and disappointment in the supervision session. The supervisor shares the information gained through their own educational research and invites the supervisee to add any additional information they may have which is important. The supervisor also discusses how their own lack of knowledge could have harmed the client and influenced their supervision of the case. They re-review the video again together to try to avoid any harm to the client due to this lack of knowledge.

Case Example: Supervisee's Lack of Knowledge A supervisee who identifies as a queer Black woman is discussing her case. She says that her client identifies as intersex which confuses her because the client's name is Ralph. She explains that he looks like a man, dresses like a man, and seems interested sexually only in women yet he identifies as a lesbian. The supervisee cannot understand why (by her definition) a man would call himself a lesbian. She then says that he must be transsexual. This supervisee is not aware that she has a lack of knowledge and that she is exposing her lack of knowledge both in her description of the client and in her conceptualization of the problem. Her supervisor, who is a queer Asian woman, is shocked that she seems to know so little about intersex individuals or the differences between gender identity and sexual orientation. The supervisor has an opportunity to help educate this supervisee. There are many resources available to expand the supervisee's knowledge base both written material and videos. If there is a gender clinic in the area the supervisor could also arrange for the supervisee

to volunteer there or to observe clinical intakes. If other more knowledgeable supervisees are seeing trans and genderqueer individuals, the supervisee might also learn a lot from observing some of those sessions behind the mirror. The supervisor also has an opportunity to explore how their different racial, cultural, identities, and life experiences may be influencing how they are each thinking about this client and case, and how those different knowledges bases might be expanded.

Over- or Under-Emphasizing Difference

Hare-Mustin (1987, p. 15) warns against "alpha bias," the exaggeration of differences between people, and "beta bias," ignoring differences that do exist. This type of binary bias minimizes the complexity of relationships. In the context of the supervisory relationship, this could mean the supervisor assumes that the experiences of the supervisee mirror those of their own, or because they identify with different parts of the queer spectrum, their experiences may be completely different. The supervisee, could, of course, do likewise.

Case Example: Beta Bias A queer supervisor is having supervision with a queer supervisee, and says, "So this client is obviously struggling, like we all have, with his relationship with his parents and acceptance. How might your own struggles with your parents influence how you view these parents?" Perhaps the queer supervisee did not struggle with parents. Do supervisees tell supervisors they did not have the same experience? Will revealing that their path has been less challenging make the supervisor think differently of them? It needs to be said, however obvious, that "queerness" in and of itself is not one cohesive thing, nor is it even many cohesive things, but rather an amalgamation of identities and behaviors only brought into being in opposition to the heteronormative order. There is no shared experience of queerness that "everyone who is queer has." Still, dominant coming-of-age narratives (e.g., "coming out"), pop culture references, and specific interpersonal struggles are commonly thought of as making up queerness. The shared language of these stories may be useful to building a "queer community," as well as useful for queer supervisors to build trusting relationships with their queer supervisees and clients, as seen in this case example; however, it creates its own structures of inclusion and exclusion as well, defining who gets to be recognized as queer and often erasing individuals who are non-white, non-cis, non-male, not upper class, etc., also seen in this case example.

The picture may be further complicated by other intersectional identities like race. For example, the notion of "Asian" or "Asian American" comes with its own set of dominant stories, including struggles with one's immigrant parents as well as perceived cultural conflict between "East" and "West," accounts of diaspora, and commercial markers (e.g., consuming bubble tea). Affirming community and peer support are two of the most important buffers against minority stress (Choi et al., 2011; Operario et al., 2008; Vu et al., 2011). "Universal" experiences, however, are more often gatekeeping standards set by cis, gay, financially secure, second-generation, East Asian American men. There is pressure to conform to or accrue these standard-setting experiences in order to gain acceptance within this already marginalized community.

In this case example, the supervisee is grappling with the standards and expectations of their supervisor, based on a superficial set of shared identifications—Am I "queer' enough? Am I 'Asian" enough? A notion of "queer" is only legible against heteropatriarchy. A notion of "Asian" is only legible against white supremacy. Neither "queer" nor "Asian" is positively defined by "struggles with your parents" as the supervisor presumes, nor should not struggling with one's parents imply an easier life course given financial hardships, immigration trauma, and other struggles common for queer and Asian individuals but often invisible in mainstream representations. The pressure to homogenize individual experiences, like that felt by the queer supervisee,

only strains the relationship between supervisee and supervisor as well as between supervisee and client. Shared understandings and experiences are undoubtedly invaluable for better care, but only if they are allowed to develop with the backdrop of an intentional diversity within the "queer experience" (or the "Asian experience"), or else risk alienation from a safe space of care.

Forms of Bias

Bias is present in supervision whether we acknowledge it or not. We all have bias. Long has noted in the past that she is less afraid of the bias within herself or within her supervisee than she is about the bias that could go unexamined in either or both of them (Long & Bonomo, 2007). In this section, we are particularly interested in all forms of bias against clients, supervisees, and supervisors based on their sexual identities, sexual orientation, and/or their gender identity.

It has long been noted that mental health professionals are ill-prepared for working with LGBTQ+ individuals, couples, and families (Laird & Green, 1995; Long, 1996; Long & Serovich, 2003; Ritter & Terndrup, 2002). Henke et al. (2009) measured couple and family therapists' levels of homophobia and self-perceived levels of competence in working with lesbian and gay clients. Their findings support the notion that training programs must incorporate various forms of LGBTQ+ awareness and information in order to decrease levels of bias and enhance clinical competency.

The knowledge base about queer families continues to expand (Bos & Gartrell, 2010) with much more still to be learned about individuals who are intersex, genderqueer, pansexual, and transgender (Tobia, 2019). Family therapy supervisors and supervisees must be exposed to this new knowledge and must also incorporate time for both self-examination and reflection regarding potential areas of bias (Long & Bonomo, 2007).

Bias comes in many forms and there are several ways that it might be present in queer supervision. It cannot be assumed that because someone identifies as LGBTQ+ they understand enough about others' specific intersectional experiences of queerness. How would a cisgender lesbian really understand the world of someone who is transitioning? How does someone who is white and queer understand the life of someone of color who is queer, or how does someone who is Jewish and queer understand the life of someone who is Muslim and queer? The LGBTQ+ community is so diverse that no one can completely understand the life of another. It is also sometimes incorrectly assumed that because the LGBTQ+ community is oppressed its members do not also hold other forms of bias; that somehow being queer exempts one from sexism, racism, classism, ageism, ethnocentrism, anti-Semitism, etc. Gay men can be sexist, queer women can discriminate based on age, and someone who is pansexual can discriminate based on class. Even within the LGBTQ community there is often stereotyping among the various subgroups. For example, Weiss (2004) provides us with a lengthy history of gay men and lesbians exhibiting biphobia and transphobia. Sometimes bias is held against others in the queer community based on how "out" they are, their relationship status, their HIV status, their lack of or involvement in advocacy, their politics, etc. Another way in which bias is held is when one is "allergic" to anything that is too gay, too queer, too butch, too gender conforming, too essentialist, etc. When others do not embody sexual orientation or gender identity in the way with which another is comfortable, they are sometimes judged for being too much or too little.

Case Example: Bias in Group Supervision A supervisor has gathered a group of queer supervisees to discuss the potential for starting a support group for gay males in your clinic. Sean identifies as a Caucasian cisgender gay male, Anna identifies as an Asian soft butch lesbian, and Marco identifies as a Latinx gender non-conforming gay male. The supervisor highlights that they have added in the past two years a support group for queer women and one for persons who identify with the trans community and notes that there have been recent requests for a group for gay men as well. Sean says he does not think a group for gay men is necessary

because they do not need one. Anna quickly agrees that there is no need for a group for gay men because they already dominate the clientele. Marco wonders aloud if all gay men would feel welcome in such a group. How can the supervisor help these supervisees examine their own potential biases and how their own identities influence their ideas about forming such a group? How can a supervisor best use this dilemma as an opportunity to think more about how people with different identities will have different concerns about such a group, and how it can be addressed in the group?

The supervisor might ask them to reflect on their own identities, to encourage them to be aware of their own social location and world view, and to write about how each of those parts of their identity might respond to the idea of a gay male support group. They could also note whether different parts of identity might even disagree with one another. The supervisor should also engage in the same reflections. The next part of the assignment might be to have them look for their own bias present in their reflections. The supervisor would read each reflection and note ideas about their biases and then meet with them individually to discuss. Then the supervisor could have the group come back together and share their reflections on their own biases including the supervisor's. The next step could be to have them reflect on ways they might address their bias and write up a plan to do so. The first author did this exercise once with a group of supervisees who ended up becoming so intrigued and bothered by their own levels of bias that we started a research project to further discover the presence of bias in the therapy room when working with LGBTQ+ clients (Long & Lindsey, 2004a, 2004b).

Another important step in the above process is that the supervisor examines their own bias in supervising this group of supervisees around this topic. If the supervisor is receiving supervision of supervision, they could also discuss with their mentor. Showing supervisees that one also must do this hard work reinforces its importance and helps them understand that the process should be ongoing.

Case Example: Examining the Supervisor's Bias A Latinx, cisgender lesbian is currently supervising a Black trans man who formerly identified as a lesbian. This is the first time she has supervised someone who chose to transition from female to male. She notices during the first supervision session that she feels a little uncomfortable with the supervisee. The supervisor is very distracted by these thoughts and realizes that her discomfort is getting in the way of providing fully present supervision. She decides after the session that it would be a good time to seek peer supervision and do a lot of reading; she purposefully seeks out a trans peer supervisor. The peer supervisor invites her to write down all the concerns she thinks she wants to discuss before their first meeting. The supervisor's list includes: What might my biases be related to his gender and his race? What potential challenges does he face as a trans supervisee? What potential challenges does he face as a Black supervisee? How is his trans identity a potential strength in working with the clients? How is his Black identity a potential strength in working with the clients? How might his trans identity raise possible issues in this case? How might we talk about the intersections of all of his identities in supervision?

The supervisor's biases might be reflected in negative or confusing feelings related to someone who transitions from a lesbian identity to a trans man identity; she may assume that the supervisee will be biased against her or against lesbian clients; she may not realize the impact of transphobia on the supervisee; she may assume that the supervisee feels safe with her because they are both members of the queer community and persons of color; and she may be unaware of rigid beliefs regarding gender on her part or on the supervisee's part that could complicate the therapy and/or the supervision. The supervisor would want to read extensively and explore these potential biases with her peer supervisor so as not to rely on her supervisee to educate her (Shipman & Martin, 2017).

Case Example: Omari and Unintentional Bias As Fong and Lease (1997) note, the majority of supervisors in this country are white. For this reason, queer supervisees of color will most likely not be paired with a supervisor from a similar racial background. There are clear issues that may come up due to the racial difference between the supervisor and supervisee, namely "unintentional racism" (Fong & Lease, 1997, p. 389). This issue may occur due to well-intentioned supervisors who ignore or avoid racial issues because they are uniformed about them. However, there are further sets of issues that occur because the supervisee is both queer and a racial minority. For example, suppose that Omari, a bisexual Black therapist, has a client, Nyote, who is also Black. Nyote expresses the idea that her status as queer threatens her position within her respective racial group because "non-reproductive sexual practices may be perceived as a threat to the group's survival" (Greene & Boyd-Franklin, 1996, p. 51), and because she fears ostracizing by her family and friends due to their non-accepting religious beliefs (Robertson & Avent, 2016). Omari may feel uncomfortable approaching his white gay male supervisor about this topic as he may feel that his supervisor will not be able to adequately address these issues because he may not be very informed about issues of religion and race. In part, Omari is concerned about discussing this case with his supervisor because he knows that he has a values conflict between his own identity as bisexual and what his church family has taught him—that his identity is sinful, and he is fearful of addressing it in his training environment.

In this example, the supervisee's multiple minority identities play a role in his level of alliance with the supervisor. If these issues are not discussed, it could damage the supervisory alliance, thus having a potential negative effect on the client and/or the supervisee. Likewise, the supervisor will want to examine his own majority racial identity in order to bolster alliance. If he has not already done so, it would be a good starting place to acknowledge all the ways he has power over this supervisee first as a white man over a Black man, as a gay man over a bisexual man, as a supervisor with more years of experience and credentials over a supervisee, and to make a plan for minimizing and addressing those differences in supervision. Another thing the supervisor may want to do before meeting with Omari is to think about all the ways he may need more knowledge to supervise the case and to note where his own bias might get in the way and then to educate himself. Consultation with another supervisor who is also Black and/or bisexual would also help lower potential bias. Spending time before supervision considering the intersection of religion and race in this instance and planning how to discuss that intersection with the supervisee would be important. These types of self-examination practices prior to and throughout supervision can help to minimize the effects of bias on the supervisory alliance.

Conclusion

There are many advantages to pairing queer supervisors with queer supervisees. It should not be assumed, however, that there are no potential negative effects of such an alliance. As with any alliance, nothing should be taken for granted, such as assuming an adequate knowledge base or assuming sameness based on identity, and queer supervisors should make sure to minimize bias and reduce the likelihood of abuses of power. Queer supervisors should acknowledge the role that queer identities play in the alliance between them and their supervisees and work to ensure queer supervisees' professional growth. At the same time, by making sure to include issues related to all forms of identity, including sexuality and gender, the queer supervisor is aiding in "the development of professionals who are proficient in their ability to work with sexual and gender minorities and in the creation of therapists who are comfortable with ambiguities and questions regarding sexuality and gender" (Brown, 1991, p. 237). In fact, we believe that the greatest growth ahead for supervisors remains to be in the area of the construction of gender, and we hope the many examples offered throughout the chapter have helped to further all supervisors on this journey of discovery.

Definitions

Biphobia: Fear and dislike of people that identify as bisexual.

Genderqueer: A person who does not subscribe to conventional gender distinctions and identifies with neither, both, or a combination of both masculine and feminine genders.

Heterosexism: A system of beliefs that favors heterosexual, monogamous, traditional relationships and lifestyles over all others.

Intersex: A person who is born with ambiguous genitalia so that their sex is not easily definable as either male or female.

Pansexual: Someone who is attracted to all people regardless of their gender; pansexuality differs from bisexuality in that pansexuals are attracted to the entire range of gender identities.

Trans man: A transgender person who now identifies as a man

Transphobia: Fear and dislike of people that identify as transgender.

Trans woman: A transgender person who now identifies as a woman.

Ze: A gender neutral pronoun similar to he or she.

References

Aasheim, L. (2012). *Practical clinical supervision for counselors*. Springer.

Alderfer, C. J., & Lynch, B. (1986). Supervision in two dimensions. *Journal of Strategic and Systemic Therapies, 5*(4), 70–73. https://doi.org/10.1521/jsst.1986.5.4.70

Alessi, E. J., Kahn, S., & Horn, R. V. D. (2017). A qualitative exploration of the premigration victimization experiences of sexual and gender minority refugees and asylees in the United States and Canada. *The Journal of Sex Research, 54*(7), 936–948. https://doi.org/10.1080/00224499.2016.1229738

Bos, H., & Gartrell, N. (2010). Adolescents of the USA National Longitudinal Lesbian Family Study: Can family characteristics counteract the negative effects of stigmatization? *Family Process, 49*(4), 559–572. https://doi.org/10.1111/j.1545-5300.2010.01340.x

Bradley, L. J., & Ladany, N. (2010). *Counselor supervision* (4th ed.). Routledge.

Brown, L. S. (1991). Commentary on the special issue of *The Counseling Psychologist*: Counseling with lesbians and gay men. *The Counseling Psychologist, 19*(2), 235–238. https://doi.org/10.1177/0011000091192007

Choi, K. H., Han, C., Paul, J., & Ayala, G. (2011). Strategies of managing racism and homophobia among U.S. ethnic and racial minority men who have sex with men. *AIDS Education and Prevention: Official publication of International Society for AIDS Education, 23*(2), 145–158. https://doi.org/10.1521/aeap.2011.23.2.145

Duncan, B. L., Miller, S. D., Wampold, B. E., & Hubble, M. (2009). *The heart and soul of change: What works in therapy* (2nd ed.). American Psychological Association. https://doi.org/10.1037/12075-000

Falender, C. A. (2018). Clinical supervision: The missing ingredient. American Psychologist, 73(9), 1240–1250. https://doi.org/10.1037/amp0000385

Fong, M. L., & Lease, S. H. (1997). Cross-cultural supervision: Issues for the white supervisor. In D. B. Pope-Davis & H. L. K. Coleman (Eds.) *Multicultural counseling competencies* (pp. 387–405). Sage.

Greene, B., & Boyd-Franklin, N. (1996). African American lesbian couples: Ethnocultural considerations in psychotherapy. In M. Hill & E. D. Rothblum (Eds.), *Women and therapy* (pp. 49–60). Haworth.

Hare-Mustin, R. T. (1987). The problem of gender in family therapy theory. *Family Process, 26*(1), 15–27. https://doi.org/10.1111/j.1545-5300.1987.00015.x

Henke, T., Carlson, T. S., & McGeorge, C. R. (2009). Homophobia and clinical competency: An exploration of couple and family therapists' beliefs. *Journal of Couple and Relationship Therapy, 8*(4), 325–342. https://doi.org/10.1080/15332690903246101

Holloway, E. L. (1995). *Clinical supervision: A systems approach.* Sage.

Hubble, M. A., Duncan, B. L., & Miller, S. D. (Eds.). (1999). *The heart and soul of change: What works in therapy?* American Psychological Association. https://doi.org/10.1037/11132-000

Kaiser, T. L. (1992). The supervisory relationship: An identification of the primary elements in the relationship and in the application of two theories of ethical relationships. *Journal of Marital and Family Therapy, 18*(3), 283–296. https://doi.org/10.1111/j.1752-0606.1992.tb00941.x

Laird, J., & Green, R. J. (1995). Introduction. *Journal of Feminist Family Therapy, 7*(3–4), 3–13. https://doi.org/10.1300/J086v07n03_02

Lapinski, J., Covas, T., Perkins, J. M., Russell, K., Adkins, D. Coffigny, M. C., & Hull S. (2018). Best practices in transgender health: A clinician's guide. *Women's Health, 45*(4), 687–703. https://doi.org/10.1016/j.pop.2018.07.007

Long, J. K. (1996). Working with lesbians, gays, and bisexuals: Addressing heterosexism in supervision. *Family Process, 35*(3), 1–6. https://doi.org/10.1111/j.1545-5300.1996.00377.x

Long, J. K., & Bonomo, J. (2007). Revisiting the Sexual Orientation Matrix for Supervision: Working with LGBTQ families. In J. J. Bigner & A. Gottlieb (Eds.), *From the inside out: Clinical interventions with families of lesbian, gay, bisexual, and transgender people* (pp. 151–166). Haworth.

Long, J. K., Lawless, J., & Dotson, D. (1996). Supervisory Styles Index: Examining supervisees' perceptions of supervisory style. *Contemporary Family Therapy, 18*(4), 589–606. https://doi.org/10.1007/BF02195719

Long, J. K., & Lindsey, E. (2004a). The Sexual Orientation Matrix for Supervision: Training MFTs to work with sexual minority clients. In J. J. Bigner & J. L. Wetchler (Eds.), *Relationship therapy with same-sex couples* (pp. 123–135). Haworth.

Long, J. K., & Lindsey, E. (2004b). The Sexual Orientation Matrix for Supervision: Training MFTs to work with sexual minority clients. *Journal of Couple and Relationship Therapy, 3*(2–3), 123–135. https://doi.org/10.1300/J398v03n02_12

Long, J. K., & Serovich, J. M. (2003). Incorporating sexual orientation into MFT training programs: Infusion and inclusion. *Journal of Marital and Family Therapy, 29*(1), 59–68. https://doi.org/10.1111/j.1752-0606.2003.tb00383.x

Miller, S. D., Duncan, B. L., & Hubble, M. A. (2004). Beyond integration: The triumph of outcome over process in clinical practice. *Psychotherapy in Australia, 10*(2), 2–19.

Operario, D., Choi, K. -H., & Han, C. -S. (2008). Dual identity among gay Asian Pacific Islander men. *Culture, Health, and Sexuality, 10*(5), 447–461. https://doi.org/10.1080/13691050701861454

Orlinsky, D. E., Rønnestad, M. H., & Collaborative Research Network of the Society for Psychotherapy Research. (2005). *How psychotherapists develop: A study of therapeutic work and professional growth*. American Psychological Association. https://doi.org/10.1037/11157-000

Peters, H. C. (2017). Multicultural complexity: An intersectional lens for clinical supervision. *International Journal for the Advancement of Counselling, 39*(2), 176–187. https://doi.org/10.1007/s10447-017-9290-2

Peterson, M. R. (1992). *At personal risk: Boundary violations in professional-client relationships*. Norton.

Quek, K., & Storm, C. (2012). Chinese values in supervisory discourse: Implications for culturally sensitive practices. *Contemporary Family Therapy, 34*(1), 44–56. https://doi.org/10.1007/s10591-011-9172-4

Ritter, K. Y., & Terndrup, A. I. (2002). *Handbook of affirmative psychotherapy with lesbians and gay men*. Guilford.

Robertson, D. L., & Avent, J. R. (2016). African American counselors-in-training, the Black church, and lesbian, gay, and bisexual-affirmative counseling: Considerations for counselor education programs. *Counseling and Values, 61*(2), 223–238. https://doi.org/10.1002/cvj.12039

Shipman, D., & Martin, T. (2017). Clinical and supervisory considerations for transgender therapists: Implications for working with clients. *Journal of Marital and Family Therapy, 45*(1), 92–105. https://doi.org/10.1111/jmft.12300

Sprenkle, D., & Blow, A. (2004). Common factors and our sacred models. *Journal of Marital and Family Therapy, 30*(2), 113–129. https://doi.org/10.1111/j.1752-0606.2004.tb01228.x

Storm, C. L., McDowell, T., & Long, J. K. (2003). The metamorphosis of training and supervision. In T. L. Sexton, G. R. Weeks, & M. S. Robbins (Eds.), *Handbook of family therapy* (pp. 431–446). Brunner-Routledge.

Tobia, J. (2019). *Sissy: A coming of gender story.* Penguin Random House.

Vu, L., Choi, K. -C., & Do, T. (2011). Correlates of sexual, ethnic, and dual identity: A study of young Asian and Pacific Islander men who have sex with men. *AIDS Education and Prevention, 23*(5), 423–436. https://doi.org/10.1521/aeap.2011.23.5.423

Weiss. J. T. (2004). GL vs. BT: The archaeology of biphobia and transphobia within the U.S. gay and lesbian community. *Journal of Bisexuality, 3*(3–4), 35–55. https://doi.org/10.1300/J159v03n03_02

Yamanis, T., Malik, M., del Rio-Gonzalez, A. M., Wirtz, A. L., Cooney, E., Lujan, M., & Poteat, T. (2018). Legal immigration status is associated with depressive symptoms among Latina transgender women in Washington, DC. *International Journal of Environmental Research and Public Health, 15*(6), 1246. https://doi.org/10.3390/ijerph15061246

Index

Note: **Bold** page numbers refer to tables; *italic* page numbers refer to figures and page numbers followed by "n" denote endnotes.

ability status: defined 33; in LGBTQ+ couples and families 33–34
accidental self-disclosure 436
accountability: positioning as 106–112; practices 108–109; therapists' communities of 108–109
accountability practices 106, 108, 118; accountability, communities of 108, 109
action: defined 31; in support of evolution of affirmative therapy 18
Addiction Severity Index (ASI) 387
addressing: multiple axes of identity and power 82–83; sexual pleasure in gay male couples 128–129
affirmative family therapy 17–21; actions in support of evolution of 18; center ethics and intersectionality 18; challenging gender binary 19–20; consider language 20; focus on training 20; intersectional clinical work 18–19; self of the therapist work 20–21
affirmative psychotherapeutic approach: gay male couples 122–123
affirmative religious organizations **359**
affirmative sex therapy with same-sex couples 121–122
affirmative therapy 393–396, 394–395; actions in support of evolution of 18; with clients practicing consensual non-monogamy 297–320
affirming queerness 239–255
Affordable Care Act 268, 327
Ainsworth, Mary 63
American Academy of Pediatrics 451
American Association for Marriage and Family Therapy (AAMFT) 417, 424, 458; Code of Ethics 46, 48, 50–52; Therapist Locator or Psychology Today's Therapist Finder 435
American Association of School Administrators 451
American Community Survey (ACS) 226
American Counseling Association 52, 451
American Federation of Teachers 451
American Medical Association 451
American Psychiatric Association (APA) 12, 207, 451; *Diagnostic and Statistical Manual of Mental Disorders* 451
American Psychoanalytic Association 451
American Psychological Association (APA) 55, 136, 350, 451; *Guidelines for Providers of Psychological Services to Ethnic, Linguistic, and Culturally Diverse Populations* (1990) 407–408; *Guidelines for Psychological Practice with Lesbian, Gay, and Bisexual Clients* (2011) 407; *Guidelines for Psychological Practice with Transgender and Gender Nonconforming People* (2015) 407; *Report of the Task Force on Appropriate Therapeutic Responses to Sexual Orientation* 453; Task Force on Gender Identity and Gender Variance 387
American Psychological Association Manual 3
American School Counselor Association 451
American School Health Association 451
anodyspareunia (pain during anal sex) 125–126
asexual person 151
Asian American LGBTQ+ partners and families 36–37
assessment: LGBQ affirmative program environment 427–428; recommendations for 244–245; religiosity and spirituality in couples' therapy 353–355; for sexual and gender minority partner violence 369–370; of trauma 41–42; universal clinical guidelines 146
assessment tools 309
assigned sex in LGBTQ+ couples and families 34
attachment theory: clinical process 65–72; and gay men 62–65; integrating couple therapy into, with gay men 61–73

Baldwin, James 1, 6
Bandura, Albert 199
bars and clubs 384
Behavioral Couples Therapy (BCT) 391, 396
being "out" and queer women couples 80
Bem, Sandra 199
Benjamin, Harry 153
best practices in couple therapy with bisexual partners 100–102
beta bias 473–474

bias: beta 473–474; forms of 474; in group supervision 474–475; supervisor's 475; unintentional 476
biphobia: and anti-Black racism 77; and bisexual woman of color 95; internalized 99; sociocultural context for 92–95
bisexual, coming out and identifying as 90–92
bisexual erasure 93–94
bisexual identity: development models 202; disclosing 96–97; theories about 202
bisexual individuals 388
bisexuality 89–92; bisexual erasure 93–94; centering 101–102; coming out and identifying as bisexual 90–92; defined 90; gender binary *92,* 92–93; intersections of minority stress 95; minority stress 94–95; prevalence of 90; sociocultural context for 92–95
Bisexuality Invisibility: Impact and Recommendations 388
bisexual partners: best practices in couple therapy with 100–102; bisexuality 89–92; centering, in couple therapy 89–102; common issues in couple therapy with 95–100; sociocultural context for bisexuality and biphobia 92–95
Black LGBTQ+ couples and families 34–35
Black Lives Matter movement 5
"blended family" 277
blurred boundaries 468–469
body maps 141–142
body size and CNM 317
bondage discipline/dominance and submission/sadism and masochism (BDSM) 204–207
boundaries: blurred 468–469; and power 466–468
Brooks, Rayshard 5
butch 19, 156, 158, 159, 474

California Health Interview Survey 365
case studies 26–28, 39–40, 176–177, 200–201, 204, 207–208, 210, 371–372, 390, 393, 395–396, 423–424, 427, 429, 449–450
centering: bisexual partners in couple therapy 89–102; ethics and intersectionality 18
CFT faculty and programs: LGBQ affirmative training strategies for 417–429
Chicago Health and Life Experiences of Women Study (CHLEW) 388
children: interpersonal practices 286; psychoeducation 285–286; in queer families 227; queer families raising 225–236; strategies for supporting 285–286; supporting through losses, loyalty binds, and pace of change 283
cisgenderism 116
cisgender partners and transgender partners 114–116
cisnormativity 93; larger structures supporting 433–435
Civil Rights Act of 1964 444
class and CNM 316–317
classical patriarchy 195
classical sex therapy with same-sex couples 121–122
clinical assessment: and negative automatic thoughts 124; for sex therapy 129–130; suggestions for 129–130
clinical intervention, suggestions for 130–131
clinical process and attachment theory 65–72
clinical work in cultural context 136–138
CNM-affirming practice 318
COAMFTE Accreditation Standards 51
Cognitive-Developmental Theory 199
cognitive-emotional approach: gay male couples 123–124
Cognitive-Emotional Model of Sexual Dysfunction 123
cognitive restructuring 124
Collaborative-Dialogical Practices 456
Collaborative Therapy (CT) 456
Collins, Patricia Hill 10
Combahee River Collective Statement 82–83
Come As You Are (Nagoski) 138
coming out: within the dominant context 196–197; gay men 64; and identifying as bisexual 90–92; impact of 64
Community Reinforcement and Family Training (CRAFT) 391
compassion fatigue 118
compersion 301
competence: in addressing spirituality and religion 358; multicultural 30–42; social justice 30–42
The Complete Gay and Lesbian Parenting Guide (Lev) 225
consensual non-monogamy (CNM) 97–99; additional clinical issues in 313–315; affirmative therapy with clients practicing 297–320; assessment tools 309; class 316–317; in families 314–315; gender 316; gender identity, body size, disability, and more 317; interventions for managing jealousy 311–312; jealousy 310–313; Marriage, Couple, and Family Therapy literature 305–307; metamour relationships 313–314; opening up 307–309; presentations in therapy 307–313; prevalence 298–299; race 315–316; relationship agreements 309–310; secondary relationships 314; self-of-therapist issues with clients 318–319; and social justice 315–317; special vocabulary for special relationships 299–305; styles of 299; therapist issues 318–319
conversion therapy 48–50

co-parents 99–100
Council for Accreditation of Counseling and Related Educational Programs (CACREP) 52
counseling: -based SOCE 452–454; culture-centered 456–458
couple and family therapists (CFTs) 417–429
couple dynamics 140
couple enrichment (CE) programs: brief history of 402–403; contemporary programs and other options 409; delivery 403; focus 403–404; helpful therapist and facilitator characteristics 409–410; introduction and terminology 401–402; recommendations for assessment and referral 407–408; recommendations for future research on 410; recommendations for providers 408–409; research on CE program outcomes 404–405; skills training 403; social issues faced by queer partnerships 405–407; typical components 403–404; use of inventories 403
couples treatment, for substance use disorder 391
couple therapy: assessing religiosity in 353–355; assessing spirituality in 353–355; integrating attachment theory into, with gay men 61–73
couple therapy, with bisexual partners: best practices in 100–102; centering bisexuality 101–102; common issues in 95–100; consensual non-monogamy 97–99; disclosing bisexual identity 96–97; from parents to co-parents 99–100; reflexive therapist practice 100–101
COVID-19 pandemic 46
Cox, Laverne 109
Crenshaw, Kimberlé 5, 25, 83, 328
critique of current ethical practices 45–47
culturally sensitive treatment 393–396
culture-centered counseling 456–458

deception and LGBT couples 390
Defense of Marriage Act 328
deliberate disclosure 435–436
demisexual person 151
desire: in context, working with 138–143; as response 137–138; in TGNBQ relationships 149–169
desire discrepancy 124, 125, 129, 135, 137, 140, 143; inhibited desire 19, 137, 138; responsive desire 137–138, 140; spontaneous desire 137–138
Diagnostic and Statistical Manual of Mental Disorders (DSM) 11, 136, 381, 425, 451
Diagnostic and Statistical Manual of Mental Disorders-5 (DSM-5) 124, 207
differentiation work 142–143
difficult dialogues 232–233, 234–235; fostering 250–252
disability and CNM 317
discipline divide 286–287; family-of-origin 288; interpersonal practices 288; psychoeducation 287; strategies for 287, 288
disclosing, bisexual identity 96–97
discrepancy in sexual desire 125
discriminatory adoption policies 406
diversity: affirming 121–131; of sexual practices, orientation, and embodiment for TGNBQ people 154–161
divorce: emotional dynamics of same-sex relationships relevant to 181–182; legal 175; same-sex 178–180, 188
divorce therapy: applications from 185–186; defined 185
dominant context: "coming out" within 196–197; gender, sexual, erotic, and relational diversity (GSERD) 195–196
dominant discourse 21, 47, 49, 50, 94, 226, 229, 231, 235, 308
Don't Ask, Don't Tell 327, 328
Drapetomania 11
dualism, hierarchical 10–11
Dynamic Model of Sexual Identity Development 202

Earth-spirited religious or spiritual communities 352
education: Catholic-based 129; self-education 162–164; sex 129, 149, 154, 162; strategies for 424–427
emotional dynamics of same-sex relationships 181–182
electronic visibility management 197
Emotionally Focused Therapy for Couples (EFT/EFCT) 306, 356
equality and marriage 3–4
erotically marginalized 149
erotic orientation 204–207
ethical decision-making around self-disclosure in therapy 436–441
ethical imperative for self-of-therapist work 55
ethics: LGBQ affirmative therapy 425; in LGBTQ-affirmative therapy 48–54; relational 47, 55; in treatment of LGBTQ clients 45–56
ethnicity: and LGBTQ+ couples and families 34; TGE youth 266–268
Eurocentric patriarchal ideology 196
Eurocentrism 196
Evergreen International 452
Ex-Gay No Way (Rix) 459
Exodus Global Alliance 452, 454
Exodus International 452, 453–454
externalizing 69, 83, 111, 186, 356

families: CNM in 314–315; connecting to support systems 266; first-time 278; queerness 242–244; role of 242–244
family-of-origin work: LGBTQ-headed stepfamilies 279–280
Family Process 14
family relationships 245
family therapy: queer elders and 327–343; in subsystems 291–292
family therapy model 229–230
femme 76, 151, 158–159, 167, 168, 317
fictive kin 118
fidelity: romantic but not sexual 300
Fifty Shades of Grey (James) 206
first author's (DC) relational intersectionality 270
first-time families 278
Floyd, George 5
Four-Stage Model of Bisexual Identity Development 202
four-stage model of family therapy 245–255

gatekeeping and LGBTQ-affirmative therapy 50–53
gay and bisexual males 388–389
Gay Lesbian and Straight Education Network (GLSEN) 241
gay male couples: affirmative psychotherapeutic approach 122–123; anodyspareunia (pain during anal sex) 125–126; case vignette 129–131; from classical sex therapy to affirmative sex therapy 121–122; cognitive-emotional approach 123–124; conclusions and future directions 131; discrepancy in sexual desire 125; DSM diagnoses for male sexual dysfunctions 124–125; HIV status 128; homonegativity and sexuality 127; relationship status 128; sex therapy for 121–131; and sexual difficulties 124–126; sexual pleasure in 128–129; social supports and internalized heterosexism 126–127; theory and research 121
gay men: attachment differences and homophobia/heterosexism 64; and attachment theory 62–65; experiencing nonmonogamy 64–65; fighting for relationships 61–62; impact of heterosexism, homophobia, and coming out 64; integrating attachment theory into couple therapy with 61–73; similarities 63
gender: CNM 316; defined 34; history of, in mental health 11–13; in marriage and family therapy 13–17
gender, sexual, erotic, and relational diversity (GSERD): assessments **211**–**212**; awareness 211; "coming out" within dominant context 196–197; dominant context 195–196; GSERD-affirming practices 210–217; identities 197–198, 210, 217; identity development 197–200; minoritized GSERD identities 198–210; resources **214**–**216**; visibility management 198–210
gender affirmative therapy: connecting family to support systems 266; engaging siblings and other family members in 263; listening to youth about what they need to feel congruent 263–265; parental attunement 260–261; psychoeducation with parents 262; structure of sessions 260–261; supporting gender expansiveness 261–262; supporting the parents' emotional process 262–263; with TGE youth and families 260–266; therapists as advocates 266
gender binary: affirmative family therapy 19–20; bisexuality *92,* 92–93; challenging 19–20; reinforcing 14; system *92*
gender congruence 150, 465
gender dysphoria 200
gender expansiveness: "gender shame" for youth expressing 259–260; supporting 261–262
gender identity 198–200; acceptance or rejection of 28; CNM 317; development of 244; first diagnosis pertaining to 12; Gender Identity Disorder 12; and LGBTQ youth of color 243; social norms of 149
gender-inclusive work 112; orienting yourself in 112; therapists 112
genderqueer 151
gender role socialization 79
Gender-Schema Theory 199
gender shame 259–260
Genocide Studies and Prevention 454
Gen Silent (documentary film) 328, 331
geographic agreements 310
Gottman, John 306
Gottman, Julie 306
Gottman Institute 406–407
Gottman Method Couple Therapy 141, 306
grief 41, 111, 145–147, 166, 200, 259, 262, 292, 429
grief and psychoeducation 292
grief work 145–146
GSERD-affirming practices 210–217

Hare-Mustin, Rachel 14
health disparity: defined 381; U.S. Department of Health and Human Services on 381
heteronormative assumptions 421–422
heteronormative gender role socialization 181
heteronormativity 4, 93, 175–176; larger structures supporting 433–435; reinforcing 15–16; in treatment of LGBTQ clients 45–56

heterosexism: attachment differences based on experiences with 64; defined 449; gay men 64; impact of 64; internalized 126–127
heterosexism constructs **457**
heterosexual identity 423
heterosexual privileges 422–423
hierarchical dualism 10–11; sociocultural context of 10–11
hierarchical polyamory 301
history of gender and sexuality in mental health 11–13
HIV/AIDS 123, 128, 406; gay male couples 128; sex therapy 128
homelessness 242
homonegativity and sexuality 127
homophobia: attachment differences based on experiences with 64; gay men 64; impact of 64
homosexuality: APA de-pathologizing 136; etiology of 12; pathological 49; pathologizing 15–16; World Health Organization on 451
hooks, bell 10
Hypoactive Sexual Desire Disorder 124

identities: addressing multiple axes of 82–83; and identity development 197–198; intersectional 244; and related privileged and oppressed statuses **32**; shifting 470
identity development 198–210; in gender, sexual, erotic, and relational diversity (GSERD) 195–217; identities and 197–198; intersection with ethnic/cultural context 197–198
immigration status, defined 34
Indigenous LGBTQ+ couples and families 37–38
Informed Consent Model 111
inhibited desire 137, 138
insider/outsider challenges: interpersonal practices 282–283; psychoeducation 282; strategies for meeting 282–283
insider/outsider positions 280–281; intersectionalities impacting, for LGBTQ stepcouples 281–282
Institute of Medicine: *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding* 382
intake session 41
intercultural issues in LGBTQ+ couple and family therapy 25–42
Interfaith Alliance Foundation 451
internalized heterosexism 126–127; social supports and 126–127
interpersonal practices: LGBTQ-headed stepfamilies 279
intersectional clinical work 18–19
intersectional considerations for TGE youth 266–269
intersectional identities 244
intersectionality 5–6; as an ethical imperative 109–110; center ethics and 18; inching toward 15; and insider/outsider positions for LGBTQ stepcouples 281–282; with lesbian couples 136; and the queer community 328–329; queer families 227–228; relational 270–271; in same-sex divorce 184
intersex 34, 93, 108, 150, 198, 199n5, 472
interventions: lesbian couples 141–143; for managing jealousy 311–312; pain and loss 144–146; sexual history assessment as 141
implicit bias 85, 109, 116, 118
intimate partner violence (IPV): assessment and treatment recommendations 368–374; assessment/screening for 369–370; barriers to accessing services 366–367; creating safe therapeutic environment 374; critical review of the literature 364–368; defined 363; prevalence rates 364–365; protective factors 368; recommendations for future research 374; risk factors and antecedents 365–366; sociopolitical context 367–368; supervision and consultation 374; therapeutic framework and strategies 372–373; treatment of sexual and gender minority partner violence 371–372
intrinsic religiosity 350
inventories, use of 403

jealousy 310–311; accessing support systems 312; developmental reframing 311; get involved 312; interventions for managing 311–312; "intimacy sandwich" 312; normalization 311; problem or symptom 312–313
Jefferson, Atatiana 5
Johnson, Virginia 121–122
Journal of Bisexuality 388

kink 204, 205, 205n10, 206, 215, 314n35
knowledge, defined 31
Kohlberg, Lawrence 199
Kovach, Margaret 83
von Krafft-Ebing, Richard: *Psychopathia Sexualis* 152
Krinsky, Lisa 331

language 34; affirmative family therapy 20; considering 20; supporting TGNBQ clients 150–151
Latinx LGBTQ+ couples and families 35–36

Lebow, J. L.: *Treating the Difficult Divorce* 185
lesbian and gay identity development models 202
lesbian couples: body maps 141–142; clinical work in a cultural context 136–138; couple dynamics 140; differentiation work 142–143; intersectionality with 136; interventions used 141–143; sensate focus exercises 142; sex therapy with 135–147; sexual history assessment as an intervention 141; stabilization via Gottman 141; universal clinical guidelines 146–147; working with desire in context 138–143; working with pain and loss 143–146
lesbian sexual desire: discrepant 137; inhibited 137; responsive 137
lesbian women 387–388
Lev, A. I.: *The Complete Gay and Lesbian Parenting Guide* 225
LGB couples: spiritual and religious involvements 350–353; therapeutic interventions with 355–356; training therapists and religious/spiritual issues 356–360
LGB couples' therapy: religion in 347–360; spirituality in 347–360
LGBQ affirmative program environment: assessment 427–428; on-site clinic 428; policies 428; recruitment 428–429; strategies for creating 427–429
LGBQ affirmative therapy: challenges of training students in 420–421; conclusion and future directions 429; course activities 426–427; course assignments 426; course content 424–425; diagnosis and assessment 425; ethics 425; lifespan development 426; practice of 418–419; preparing students to provide 419–420; research methods 425–426; strategies for creating LGBQ affirmative program environment 427–429; strategies for self-of-the-faculty exploration 421–424; strategies for training and education 424–427
LGBQ affirmative training strategies for CFT faculty and programs 417–429
LGBT community: and people of color issues 81; and racism 383; substance use in 381–385
LGBT couples: assessment 387; bars and clubs 384; bisexual individuals 388; case example 385–387; changing family dynamics 385; coming out process 383–384; culturally sensitive treatment 393–396; deception 390; experiencing substance use disorders 381–396; family repercussions 384–385; gay and bisexual males 388–389; impact of substance use on couples 384; lesbian women 387–388; level of care 389–390; minority stress 383; nuanced treatment approaches for 391–392; obstacles to treatment 386–387; preliminary treatment considerations 387–390; progressive mental health condition 385; substance use in LGBT community 381–385; transgender individuals 387; treatment approaches 390–393; withdrawal management 389
LGBT individuals: and twelve-step groups 392–393
LGBTQ affirmative couple and family therapy 9–21; affirmative family therapy 17–21; gender and sexuality in marriage and family therapy 13–17; history of gender and sexuality in mental health 11–13; sociocultural context of hierarchical dualism 10–11; sociocultural context of patriarchy 10–11
LGBTQ-affirmative therapy: affirming trans identities 54; common ethical issues in 48–54; conversion therapy 48–50; referring clients out 53–54; training issues and gatekeeping 50–53
LGBTQ clients: critique of current ethical practices 45–47; envisioning the future 55–56; ethical issues in LGBTQ-affirmative therapy 48–54; ethics in treatment of 45–56; heteronormativity in treatment of 45–56; shifting to relational ethics 47; a way forward 55
LGBTQ+ couple and family therapy: case study 26–28; impact of oppression on LGBTQ+ intimacy 28–29; intercultural issues in 25–42; LGBTQ+ resilience 29–30; multicultural and social justice competence 30–42
LGBTQ+ couples and families: ability status in 33–34; assigned sex in 34; Black 34–35; ethnicity in 34; Indigenous 37–38; Latinx 35–36; multiracial 39; race in 34; religion in 34; spirituality in 34; White 38–39
LGBTQ Divorce and Relationship Dissolution 176
LGBTQ+ identities: multiple and interlocking 33; problematizing 16
LGBTQ+ intimacy, oppression on 28–29
LGBTQ+ oppressions: interlocking 33; multiple 33
LGBTQ+ partners and families: Asian American 36–37; Pacific Islander 36–37
LGBTQ people studied as monolith 16–17
LGBTQ+ resilience 29–30
LGBTQ stepcouples: intersectionalities impacting insider/outsider positions for 281–282
LGBTQ stepfamilies: building new family culture 288–289; differing values about money 289; discipline divide 286–287; family-of-origin 288; five major challenges

for 280–291; insider and outsider positions 280–281; interpersonal practices 282–283, 286, 288, 290, 291; intersectionalities and LGBTQ stepcouples 281–282; losses 283; loyalty binds 283–284; overview 277–279; pace of change 284–285; post divorce co-parenting 290–291; psychoeducation 282, 285–286, 287, 289, 291; strategies for building new family culture 289, 290; strategies for discipline divide 287, 288; strategies for meeting insider/outsider challenges 282–283; strategies for post-divorce co-parenting 291; strategies for supporting children 285–286; supporting children through losses, loyalty binds, and pace of change 283; therapy with 291–293; three-level framework for therapy 279–280
LGBTQ youth and minority stress 241
LGBT substance use health disparities 382–383
Life Isn't Binary (Barker and Iantaffi) 109
losing face, concept of 36
Loving More magazine 305

Machado, Carmen 9
male privilege 38–39, 167
male sexual dysfunctions: DSM diagnoses for 124–125
marginalized identities 19, 29, 32, 33, 78, 95, 151, 266, 268, 363, 368, 418, 429, 437, 439, 440, 459
Marriage, Couple, and Family Therapy (MCFT) literature 305–307
Marriage and Family Therapy (MFT) 10–11, 13–14; considering race 17; gender in 13–17; inching toward intersectionality 15; LGBTQ people studied as monolith 16–17; pathologizing homosexuality, reinforcing heteronormativity 15–16; problematizing LGBTQ identity 16; reinforcing the gender binary 14; sexuality in 13–17
Marriage Enrichment: Preparation, Mentoring, and Outreach (Hunt) 404
marriage equality 3–4
Masters, William 121–122
mediation and same-sex couples 187
medical providers: referrals to 147; referral to 144
mental health: effects of oppression on 26; history of gender and sexuality in 11–13; literature 20; and minority stress 94–95
men who have sex with men (MSM) 389
metamour relationships 313–314
Metropolitan Community Church (MCC) 352, 456
Meyer, I. H. 94, 367, 383
minoritized GSERD identities 198–210
minority stress 383; bisexuality 94–95; intersections of 95; LGB couples' coping through spiritual and religious involvements 350–353; LGBT couples 383; and LGBTQ youth 241; queer women couples 79; religion-based sources of 349–350
mixed orientation relationships 113
monogamish 300n8
monogamy 307n28
monolith, LGBTQ people studied as 16–17
mononormativity 93, 315
mono/polyamorous relationship 304–305
monosexism 90
monosexuality 89
Movement Advancement Project 62
Multicultural and Social Justice Counseling Competencies: ability status in LGBTQ+ couples and families 33–34; Asian American and Pacific Islander LGBTQ+ partners and families 36–37; assessment of trauma 41–42; assigned sex in LGBTQ+ couples and families 34; Black LGBTQ+ couples and families 34–35; Indigenous LGBTQ+ couples and families 37–38; intake session 41; Latinx LGBTQ+ couples and families 35–36; multiple and interlocking LGBTQ+ oppressions and identities 33; multiracial LGBTQ+ couples and families 39; potential strategies and considerations 40–41; race and ethnicity in LGBTQ+ couples and families 34; religion and spirituality in LGBTQ+ couples and families 34; White LGBTQ+ couples and families 38–39
multicultural competence 30–42
multidimensional/intersectional development models 202–204
multiple and interlocking LGBTQ+ oppressions and identities 33
multiple identity development 33
multiple minority stress 79, 112, 118
multiple relationships and self-disclosure 319
multiracial feminist couple therapy with queer women 75–85
multiracial feminist therapy considerations 76–78
multiracial LGBTQ+ couples and families 39

Nagoski, E.: *Come As You Are* 138
National Association for the Research and Therapy of Homosexuality (NARTH) 452, 454
National Association of School Psychologists 451
National Association of Secondary School Principals 451
National Association of Social Workers 451

National Coalition of Anti-Violence Programs (NCAVP) 327, 387
National Education Association 451
National Institute on Drug Abuse (NIDA) 382, 390
National Intimate Partner and Sexual Violence Survey 364
nationalism 34
new family culture: building 288–289; interpersonal practices 290; psychoeducation 289; strategies for building 289, 290
non-suicidal self-injury [NSSI] 205
non-binary 19, 89, 264; experiences 239n1, 264
non-escalator relationships 314
non-hierarchical polyamory 303–304
Non-Linear Model of Queer Couple Development 202, *203*
non-monogamy: consensual 97–99; gay men experiencing 64–65
nuanced treatment approaches for LGBT couples 391–392

Obama, Barack 4, 327
Obergefell decision 3, 176, 178–179, 290
Ochs, Robyn 90, 94
on-site clinic 428
open relationships 300
oppression: defined 32; on LGBTQ+ intimacy 28–29

Pacific Islander LGBTQ+ partners and families 36–37
pain and loss: grief work 145–146; interventions used 144–146; referral to medical providers 144; touch continuum 145; working with 143–146
pansexual 151
parental attunement: assessing 260–261; and deciding on structure of sessions 260–261
parents 99–100; psychoeducation with 262; queer women couples 80; supporting emotional process of 262–263
partner violence: gendered models of 366; perpetrators of 366; prevalence estimates of 365; in sexual and gender minority couples 363–375
pathologizing homosexuality 15–16
patriarchy: classical 195; defined 195; sociocultural context of 10–11; in Western societies 196
peer relationships 244–245
pleasure, targeting 121–131
plurality: romantic 300–305; sexual 300–305
plurisexuality 89
polyamory 300, 300n13; hierarchical 301; non-hierarchical 303–304; solo 303, 304
polyfidelity 301–303
polyvictimization 242
Population Reference Bureau 25
positioning as accountability 106–112
post-divorce co-parenting 290–291; interpersonal practices 291; psychoeducation 291; strategies for 291
power: addressing multiple axes of 82–83; and boundaries 466–468; queer supervision 469–470
pre-emptive radical inclusion (PRI) 135
Premature Ejaculation 125
presentations in therapy 307–313
prevalence: of bisexuality 90; consensual non-monogamy (CNM) 298–299; intimate partner violence (IPV) 364–365
privilege, defined 32
problematizing LGBTQ identity 16
pronouns: ze/hir/hirs 151
A Provider's Introduction to Substance Abuse Treatment for Lesbian, Gay, Bisexual, and Transgender Individuals document 381
Prude, Daniel 5
psychoeducation 146–147; and grief 292; LGBTQ-headed stepfamilies 279; with parents 262; and shame 292
Psychopathia Sexualis (von Krafft-Ebing) 152
PsycINFO database 216

queer community and intersectionality 328–329
queer elders: challenges of 329–342; and family therapy 327–343
queer families 225–235; and children 225–236; children in 227; creating refuge 230–232, 233–234; difficult dialogues 232–233, 234–235; family therapy model 229–230; first case example 230–233; intersectionality 227–228; nurturing queerness 233, 235; queer parents 226; resilience 228–229; second case example 233–235
queering sex therapy with TGNBQ clients 161–168
queerness: affirming 239–255; four-stage model of family therapy 245–255; historical context 240–242; homelessness 242; minority stress and LGBTQ youth 241; nurturing 233, 235, 252–253; recommendations for assessment 244–245; role of families 242–244; school concerns 241–242
queer parents 226
queer partnerships: social issues faced by 405–407; strength and resilience 406–407; stress and vulnerability 406

queer supervisee 472
queer supervision 465–477; beta bias 473–474; bias in group supervision 474–475; blurred boundaries 468–469; boundaries and power 466–468; case example 468–476; examining the supervisor's bias 475; factors in all supervisory relationships 466–476; forms of bias 474; ignoring one's identity 471; Omari and unintentional bias 476; openness 470–471; over- or under-emphasizing difference 473; overview 465–466; power 469–470; queer supervisee 472; shifting identities 470; supervisee's lack of knowledge 472–473; supervisor's lack of knowledge 472
queer women: literature review 78–82; multiple axes of identity and power 82–83; multiracial feminist couple therapy with 75–85; multiracial feminist therapy considerations 76–78; self of the therapist 84–85; shared language promoting social justice 83–84; therapy with queer women couples 76–78; using a multiracial feminist couples approach with 82–85
queer women couples: being "out" 80; gender role socialization 79; minority stress 79; parenting challenges 80; research on QWOC and couples 80–82; societal issues faced 76–77; strengths of queer women couples 77–78; therapy with 76–78

race/racism: CNM 315–316; considering 17; and LGBT community 383; in LGBTQ+ couples and families 34; MFT 17; TGE youth 266–268
recruitment and LGBQ affirmative program environment 428–429
referrals to medical providers 144, 147
reflexivity 116, 313
reflexive therapist practice 100–101
refuge, creating 230–234, 246–249
reinforcing: gender binary 14; heteronormativity 15–16
relational ethics 47; embracing 55
relational intersectionality 270–271; and self-of-the-therapist 270–271
relational orientation 208–210
relationship agreements 309–310; examples of 310
relationship anarchy (RA) 304
relationship dissolution in same-sex couples 179–181
relationships: gay men fight for 61–62; metamour 313–314; mixed orientation 113; non-escalator 314; open 300; secondary 314; self-disclosure and multiple 319; special vocabulary for special 299–305; between transgender and cisgender partners 114–116; between transgender partners 116–117; well-being for trans and nonbinary 117
relationship status 128
religion: competence in addressing 358; in LGB couples' therapy 347–360; in LGBTQ+ couples and families 34; and TGE youth 269
religion-based SOCE 451–452
religion-based sources of minority stress 349–350
religious beliefs and traditions 348
"reparative therapy" 452
research: gay male couples 121; paucity of 136–137; on QWOC and couples 80–82; sex therapy 136–137
resilience: LGBTQ+ 29–30; queer families 228–229; queer partnerships 406–407
resiliency and therapeutic considerations 182–184
"responsive desire" 137–138
risk and therapeutic considerations 182–184
Rix, Jallen: *Ex-Gay No Way* 459
Robinson, Christine 454
romantic but not sexual fidelity 300
romantic plurality 300–305

safety: and decision-making process 437; emotional 261; organizational 394; of TGE people 267; transgender-inclusive couple therapy 117
SAGE 331
same-sex couples: additional treatment and intervention considerations 184–187; affirmative sex therapy with 121–122; applications from divorce therapy 185–186; classical sex therapy with 121–122; future research and conclusions 187–188; general considerations 184–185; mediation 187; relationship dissolution in 179–181; therapeutic considerations in issues of risk and resiliency 182–184
same-sex divorce: emotional dynamics of 181–182; intersectionality in 184; legal context 178–179; literature review 178–182; relationship dissolution in same-sex couples 179–181; therapeutic considerations in 175–188
same-sex marriage 1, 3, 52, 62, 153, 175, 178–179, 187, 327, 404, 406, 433, 453
Savage, Dan 300n8
School Social Work Association of America 451
screening for sexual and gender minority partner violence 369–370
secondary relationships 314
selective outness 196–197

self-care 117
self-disclosure: accidental self-disclosure 436; defined 433; deliberate disclosure 435–436; and ethical decision-making 436–441; and heteronormativity and cisnormativity 433–435; and multiple relationships 319; as a supervisee 441–442; as a supervisor 442–444; types of 435–436; unavoidable self-disclosure 436
self-education 162–164
self-of-the-faculty exploration: construction of heterosexual identity 423; exploring heteronormative assumptions 421–422; exploring heterosexual privileges 422–423; questions **422**
self-of-therapist work 20–21; ethical imperative for 55
self-of-the-therapist 84–85; issues with CNM clients 318–319; and relational intersectionality 270–271
sensate focus exercises 142
Sequential Family Addictions Counseling Model 391
sex and transgender-inclusive couple therapy 113–114
sex education 129, 149, 154, 162
sexism, defined 34
sex therapy: desire as a response 137–138; for gay male couples 121–131; with gay male couples 126–129; HIV status 128; homonegativity and sexuality 127; intersectionality with lesbian couples 136; with lesbian couples 135–147; lesbian sexual desire 137; paucity of research 136–137; relationship status 128; sexual pleasure in gay male couples 128–129; social supports and internalized heterosexism 126–127; suggestions for clinical assessment 129–130; suggestions for clinical intervention 130–131
sex therapy model for working with TGNBQ people 162–163
sexual and gender minority partner violence: assessment/screening for 369–370; treatment of 371–372
Sexual Configurations Theory 202
Sexual Crucible model 142
sexual desire: discrepancy in 125; lesbian 137
sexual difficulties and gay male couples 124–126
sexual history: assessment 141; history of TGNBQ sexuality 152–154
sexual identity development 244
sexuality: and genderqueer (TGNBQ) relationships 149–169; history of, in mental health 11–13; homonegativity and 127; in marriage and family therapy 13–17; and nonbinary relationships 149–169; and transgender relationships 149–169
sexual orientation 201, 453
sexual orientation change efforts (SOCE): Collaborative Therapy (CT) 456; counseling-based SOCE 452–454; culture-centered counseling 456–458; described 449; harmful effects of 454–456; helping SOCE survivors inside therapy office 456–458; helping SOCE survivors outside therapy office 458–459; origins of 450–451; overview 449–450; past and present 450–454; recovery from 449–460; religion-based SOCE 451–452; strengths-based perspective 458; understanding 450–454
sexual orientation identity 453
sexual pleasure in gay male couples 128–129
sexual plurality 300–305
shame and psychoeducation 292
shared language and social justice 83–84
similar-gender couple 201
skills 31; training 403
SOCE survivors: helping inside the therapy office 456–458; helping outside the therapy office 458–459
social issues faced by queer partnerships 405–407
social justice: and CNM 315–317; competence 30–42; shared language promoting 83–84
Social Learning Theory 199
social stigma and support 245
social support: and internalized heterosexism 126–127; transgender-inclusive couple therapy 117–118
societal oppression of TGNBQ clients 151–152
sociocultural context: for bisexuality and biphobia 92–95; of patriarchy and hierarchical dualism 10–11
socioeconomic status and TGE youth 268
solo polyamory 303, 304
special relationships, special vocabulary for 299–305
special vocabulary for special relationships 299–305
spirituality: competence in addressing 358; defined 347; in LGB couples' therapy 347–360; in LGBTQ+ couples and families 34; and religiousness 347
Spitzer, Robert 453
Spivey, Sue 454
spontaneous desire 137–138
stability and transgender-inclusive couple therapy 117
stepfamilies: family therapy in subsystems 291–292; and first-time families 278; guidelines for healing old bruises 292;

many forms of 278–279; proactively build chosen family 293; as process not an event 293; psychoeducation meeting shame and grief 292
strategies: for building a new family culture 289, 290; for creating an LGBQ affirmative program environment 427–429; for the discipline divide 287, 288; for meeting insider/outsider challenges 282–283; for post-divorce co-parenting 291; for self-of-the-faculty exploration 421–424; for supporting children 285–286; for training and education 424–427
strengths: queer partnerships 406–407; of queer women couples 77–78
strengths-based perspective 458
stress and queer partnerships 406
Substance Abuse and Mental Health Services Administration (SAMHSA) 386–387, 394; Center for Substance Abuse Treatment 381; National Survey of Substance Abuse Treatment Services 386
substance use disorders: couples treatment for 391; treating LGBT couples experiencing 381–396; treatment of 391
substance use in LGBT community 381–385
suicide 22, 37, 38, 49, 151, 262, 264, 367, 450, 454, 457
supervisee: lack of knowledge 472–473; self-disclosure as 441–442
supervision and consultation: intimate partner violence (IPV) 374
supervisor: bias 475; lack of knowledge 472; self-disclosure as 442–444
swinging 300

Taylor, Breonna 5
terminology supporting TGNBQ clients 150–151
TGE youth 269, 273; gender affirmative therapy with 260–266; intersectional considerations for 266–269; race/ethnicity 266–268; religion 269; socioeconomic status 268
TGNBQ clients: queering sex therapy with 161–168; societal oppression of 151–152; terminology and language supporting 150–151
TGNBQ eroticism 149
TGNBQ individuals and their partners: identifying therapeutic needs of 163–164
TGNBQ people: diversity of sexual practices, orientation, and embodiment for 154–161; impact of medical treatments for 159–161; sex therapy model for working with 162–163; sexual challenges 156–159
TGNBQ sexuality 152–154
therapeutic alliance, establishing 357
therapeutic considerations: intimate partner violence (IPV) 372–373; in issues of risk and resiliency 182–184; in same-sex divorce and relationship dissolution 175–188
therapeutic interventions with LGB couples 355–356
therapeutic needs of TGNBQ individuals and their partners 163–164
therapist position 147
therapists: as advocates 266; CNM-affirming practice 318; communities of accountability 108–109; competence in addressing spirituality and religion 358; consensual non-monogamy 318–319; establishing a therapeutic alliance 357; gender-inclusive work 112; intersectionality as ethical imperative 109–110; positioning as accountability 106–112; role of 358–360; self-disclosure and multiple relationships 319; self of 84–85; self-of-therapist issues with CNM clients 318–319; supporting trans people of color 111–112; and transgender and nonbinary couples 105–118; transition as dynamic process 110–111
therapy: ethical decision-making around self-disclosure in 436–441; presentations in 307–313; with queer women couples 76–78
they/them/theirs, xe/xem/xyers 151
Time Magazine 109
Title VII statute of the Civil Rights Act of 1964 444
touch continuum 145
training: affirmative family therapy 20; LGBTQ-affirmative therapy 50–53; strategies for 424–427; therapists to be effective with LGB couples' issues 356–360
trans and gender expansive (TGE) youth and families: case example 271–272; gender affirmative therapy with 260–266; "gender shame" for youth expressing gender expansiveness 259–260; intersectional considerations for TGE youth 266–269; relational intersectionality and self-of-the-therapist 270–271
trans couple 166, 458
transformation, encouraging 254–255
transgender 150
transgender, nonbinary, and genderqueer (TGNBQ) relationships: desire landscapes in 149–169; sexuality landscapes in 149–169
transgender and nonbinary couples: positioning as accountability 106–112; therapists'

accountability and engagement with 105–118; transgender-inclusive couple therapy 112–118
transgender-inclusive couple therapy 112–118; cisgenderism 116; mixed orientation relationships 113; relationships between transgender and cisgender partners 114–116; relationships between transgender partners 116–117; safety 117; self-care 117; sex 113–114; social support 117–118; stability 117; well-being for trans and nonbinary relationships 117
transgender individuals 387
transgender partners: relationships between 116–117; relationships between cisgender and 114–116
transgender people: safety 117; self-care 117; social support 117–118; stability 117
The Transgender Teen (Brill and Kenney) 109
trans identities, affirming 54
transition as dynamic process 110–111
trans-male 151, 154–160, 167
trans people of color: supporting 111–112; therapists 111–112
transphobia 81, 105, 106, 109, 111, 112, 114, 117, 118, 200, 200n6, 201, 226, 234, 260, 266, 267, 269, 317, 366–368, 439–441, 458, 472, 474, 475
trans youth 54, 264, 266, 267
trauma: assessment of 41–42; -informed treatment 393–394, 393–396
Treating the Difficult Divorce (Lebow) 185
treatment: LGBT couples experiencing substance use disorders 381–396; of partner violence in sexual and gender minority couples 363–375; of sexual and gender minority partner violence 371–372
triple jeopardy 79
Trump, Donald 4
twelve-step groups and LGBT individuals 392–393

unavoidable self-disclosure 436
unintentional bias 476
Unitarian Universalist Church 352
United Nations 327
United Nations Convention on the Prevention and Punishment of the Crime of Genocide (UNCG) 454–455
universal clinical guidelines 146–147; assessment 146; psychoeducation 146–147; referrals to medical providers 147; therapist position 147
U.S. Census Bureau 226
U.S. Department of Health and Human Services 381

values about money 289
vicarious/secondary trauma 118
visibility management 198–210; in gender, sexual, erotic, and relational diversity (GSERD) 195–217
vulnerability and queer partnerships 406

Ward v Wilbanks 53
Watts-Jones, Dee 84
well-being for trans and nonbinary relationships 117
Western European societies 196
Westernization movement 196
Westernized cultures 195
White LGBTQ+ couples and families 38–39
white privilege 38, 39, 107, 144, 149n1, 180, 457
White Supremacist Colonialist Patriarchy (WSCP) paradigm 11–13, 18–19, 21
white supremacy 93
Williams Institute 195
withdrawal management 389
women: African American 35; lesbian 387–388; oppression and objectification of 38–39; racially minoritized 14; and right-wing authoritarianism 4
World Health Organization 451
World Professional Association for Transgender Health (WPATH) Standards of Care (SOC) 111
Worldwide Marriage Encounter 404–405